



**Instructions for Completing and Entering the
LTCC Screening Document and
Health Risk Assessment into MMIS for the
MSC+ and MSHO Programs**

Developed by the Aging and Adult Services Division
Of the Continuing Care Administration
Department of Human Services
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Introduction

The information in this manual beginning with the July 2018 version, focuses on using the Health Risk Assessment form 3428H, the Health Risk Assessment Screening Document form DHS-3427H as well as the LTC screening document DHS-3427 for full assessments in the community or nursing home. An online version of this manual is on [eDocs](#) by searching for form DHS-4669.

Updates to this manual since April 2020 are identified in the below table and in *italic* in the online manual.

Chapter	Section	Change
Terms and Definitions		
One	101.06	Updated the list of provider types.
Two	201.04	Fields 34 and 35 are no longer mandatory for LTC screening document
	201.05	Added the exit codes used with activity type 07.
	201.07	Deleted the Current and Planned Program Types fields as not mandatory.
	201.12	Deleted the Current and Planned Program Types fields as not mandatory for the ECS program.
	201.13	Edit 672 will not post when exiting CDCS and the total authorized amount now exceeds the EW cap.
Three	301.01	The video conferences sponsored by the Aging and Adult Services Division are suspended for the remainder of 2020.

DHS Staff Contacts

MSHO and MSC+ Project Coordinator (651) 431-2517

Special Needs BasicCare (SNBC) Program (651) 431-2516

The [Community Based Services Manual](#) is a resource for administering home and community-based services programs (HCBS).

Address questions regarding the policies and procedures of the HCBS programs to the Disability and Aging PolicyQuest. Lead agencies (county, tribal, and managed care organization) have an administrator who may give you access to submit questions. All

questions and answers are searchable by the public. For more details, please see the [PolicyQuest](#) page in the Community Based Services Manual.

Resource Center

What we do:

- Assist staff to resolve edits and error messages on screening documents
- Assist staff with policy and technical issues related to screening documents entry into MMIS
- Process screening deletion requests. There is a weekly process of the screening document deletion requests. Resource Center staff process requests submitted by Wednesday afternoon by the end of the week. By fax only using the Screening Deletion Request form (DHS-4689A).

The Resource Center encourages E-mail as the primary method of contact for the following types of requests. On all e-mails include:

- Contact name and phone number (required)
- Explanation of issue (required)
- PMI (Personal Master Index) number and last 3 digits of screening document (as applicable)
- Edit number or MMIS message posting (as applicable)

Contact the Resource Center

DHS.ResourceCenter@state.mn.us

Resource Center staff is available Monday through Friday from 8:00 a.m. to 4:00 p.m.

Contacts for Identifying Care Coordinators

If you are trying to identify the name of the care coordinator for an individual, please reference form DHS-6581A on [eDocs](#).

Use the Managed Care Organization/County/Tribal Agency Communication form DHS-5841 to facilitate communication between the disability waiver case manager and the MCO staff.

Terms and Definitions

Alternative Care Program (AC). A program that pays for home and community-based services for people aged 65 and older who meet the nursing facility level of care criteria, and who, if they enter a nursing facility, will be eligible for Medical Assistance within 180 days of admission. Previously state-funded, the AC program now receives federal financial participation.

Applicant. A person who has submitted an application to participate in one of the publically funded health care programs including the waiver or Alternative Care programs.

Assessment. The process of identifying a person's strengths, preferences, functional skills, natural supports, and need for support and services.

Brain Injury waiver. BI is a Medical Assistance program that funds home and community-based services (HCBS) for people under age 65 who require the level of care provided in a nursing facility or neuro behavioral hospital, and who choose to reside in the community. This program provides funding for children and adults who have an acquired or traumatic brain injury. BI Waiver services may be provided in a person's own home, in his/her biological or adoptive family's home, in a relative's home (e.g. sibling, aunt, grandparent etc.), in a family foster care home, in a corporate foster care home, in a board and lodging facility or in an assisted living facility. If married, a person may receive BI Waiver services while living at home with his or her spouse.

CAC. Community Alternative Care is a Medical Assistance home and community-based services program that pays for health care and other services for an individual who requires the level of care of a hospital.

CADI. Community Access for Disability Inclusion is a Medical Assistance program that funds home and community-based services for people under age 65 who require the level of care provided in a nursing facility, and who choose to reside in the community. Community Alternatives for Disabled Individuals changed to Community Access for Disability Inclusion effective August 1, 2016.

Care Coordinator for MSHO and MSC+ Members. An individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO or MSC+ members, and who coordinates services to an MSHO member among different health and social service professionals and across settings of care. This individual must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.

Care Management for SNBC. *The assignment of an individual who coordinates Medicare and Medicaid health services for a member.*

Care Plan. The document developed in consultation with the member, the member's treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the member's family, caregiver, or representative that, taking into account the extent of and need for any family or other supports for the member, identifies the necessary health and Home and Community-Based services to be furnished to the member.

Case Manager. A county or tribal case manager (also referred to as a Services Coordinator) is a social worker, a registered nurse or public health nurse employed by or under contract with the local lead agency to provide case management.

Case Management for SNBC. The assignment of an individual who coordinates Medicare and Medicaid health services for a member.

Case Manager for MSC+ Members. An individual who coordinates Medicaid health and long-term care services for an MSC+ members receiving Elderly Waiver Services among different health and social service professionals and across settings of care.

Case Mix Classification. A classification of a person for purposes of establishing payment levels that relies on the ability to complete certain Activities of Daily Living (ADL), the need for behavioral interventions, and clinical or nursing care required. Developed as a payment system for nursing facilities; used for establishing individuals community budgets under various public programs.

Claims Adjudication. Final decision by the Department regarding service payment.

CMS. The Center for Medicare and Medicaid Services is the federal agency that oversees health care and waiver programs.

Commissioner. The Commissioner of the Minnesota Department of Human Services.

Community-Based Care. Health and social services and supports provided to an individual or family in a non-institutional setting for the purpose of delaying or preventing institutionalization by promoting, maintaining, or restoring health and independence, or minimizing the effects of illness and disability.

Consumer Directed Community Supports (CDCS). CDCS is a service option within the home and community-based programs that gives individuals more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff. CDCS may include traditional goods and services, as well as additional allowable services that provide needed support to recipients.

Consumer Support Grant (CSG). A direct grant to a qualified consumer to assist the consumer in purchasing the supports needed to live as independently and productively as possible in the community.

Conversion. For purposes of coding program type “conversion” is a person who was a resident of a long term care facility at the time of the initial referral for an assessment. For purposes of payment, people who were residents of a facility for at least thirty days may qualify for case mix rates higher than diversions or conversions with less than a thirty day stay.

Coordination of Benefits. The planning and coordination of services when more than one funding source is responsible for purchasing services.

County Based Purchasing. CBP, a managed care organization, operates by a county or group of counties. The CBP entity purchases or provide health services to MA and

MinnesotaCare recipients residing in their counties. The Minnesota legislature authorizes the program.

Data Validity. The automatic editing by MMIS of submitted data to check that data fields are of the proper type and in the proper format.

Department. Minnesota Department of Human Services (DHS).

Diversion. An assessment for a person who resulted in the prevention or delay of nursing home admission. A “diversion” is a person who is not a resident of a long term care facility at the time of the initial referral for an assessment. A person will remain diversion until exited from the waiver or AC program.

DRG. Diagnosis-Relation Group is a classification of procedures used to sort hospital patients by discharge diagnosis into categories that are medically similar and have approximately equivalent lengths of stay. Medical Assistance and the Community Alternative Care program utilizes DRGs.

Durable Medical Equipment. Durable medical equipment is a device that can withstand repeated use. It corrects or accommodates a physiological disorder or physical condition, and is suitable for use in the person’s residence. If purchased through Medical Assistance, Elderly Waiver or the Alternative Care programs, the equipment belongs to the person.

Elderly Waiver Program (EW). A Medical Assistance program that funds home and community-based services for people 65 and older who require the level of care provided in a nursing facility, and who choose to reside in the community.

Essential Community Supports (ECS). As of January 1, 2015 Individuals residing in nursing homes or who are no longer eligible for the Elderly Waiver, Alternative Care, Brain Injury Waiver-NF, or Community Access for Disability Inclusion (CADI) programs due to not meeting the level of care standards may be eligible to receive services under this program to provide transition support and community services.

Exceptions or Edits. Errors posting against a screening document or service agreement during editing in MMIS.

Extended Services. Services covered under EW and other waiver programs that exceed the scope, amount, frequency, and duration of a comparable regular (state plan) Medical Assistance service, e.g. “extended personal care”, or “extended supplies and equipment”.

Fiscal Year. A period of time established for budgetary and accounting purposes. The state fiscal year is July 1st to June 30. The federal fiscal year is October 1st to September 30.

Formal Caregivers. Formal caregivers are persons or entities providing services by or under contract with a lead agency or other agency or organization, public or private. Formal caregiver does not include the case manager.

Health Risk Assessment (HRA). *A questionnaire that assists to identify a person's health care needs, health status, and health risk factors.* The purpose of the HRA is to help care coordinators set up health related appointments and needed services as soon as possible with a member. HRAs gather information regarding persons' needs related to Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADLs). See the forms DHS-3428H and 3427H.

Home Care Provider. An individual, organization, association, corporation, unit of government or other entity that is regularly engaged in the delivery, indirectly or by contractual agreement, of home care services for a fee. At least one home care service provided directly or by contractual agreement.

Home Health Agency. A public or private agency or organization, or part of an agency or organization that holds a comprehensive home care license from the Minnesota Department of Health (MDH). In order to receive Elderly Waiver and Alternative Care funding, it must also be Medicare certified.

Hospice. A program provided either directly or on a consulting basis that provides palliative and supportive care for terminally ill patients and their families with the patient's physician or other community agencies.

Hospital. An institution primarily engaged in providing, by or under the supervision of a physician, the diagnostic and therapeutic services for the medical diagnosis, treatment, and care of injured, disabled or sick inpatients. Hospitals classified by length of stay, as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, etc.) or by type of ownership or control (federal, state, local government, for-profit or nonprofit).

Informal Caregivers. Informal or primary caregivers are family, friends, neighbors and others who provide services and assistance to persons without reimbursement for the services or support. Informal caregivers provide routine, dependable support and assistance to the individual.

Information Transfer System (ITS). A PC computer-based system that allows forms such as screening documents, service agreements, prior authorizations, and claim forms to be "batched entered" into the MMIS.

Informed Choice. The decision a person participating in a home and community-based program makes about services, including the decision to receive services either in a community or facility setting, after receiving information about all available options and

the right to choose from among these options, including choices between services and providers.

Instrumental Activities for Daily Living (IADL). Activities necessary for independent functioning including shopping, cooking, doing housework, managing money, and using the telephone. Frequently used to measure functional capacity to perform these activities to determine aspects of cognitive and social functioning.

Lead Agency

For purposes of long term consultation include counties, tribes, managed care organizations under contract with the department to manage and administrator HCBS programs.

Level of Care Determination. One outcome of assessment. The professional decision regarding a person's need for the level of care a facility provides. Facility level of care can be an acute or psychiatric hospital, a certified nursing (including a certified boarding care) facility, or an intermediate care facility for persons with developmental disabilities (ICF/DD). Long Term Care Consultants make determinations about the need for the level of care a nursing facility provides based on criteria provided by the Department and professional judgment. Determinations of other levels of care require the involvement of other qualified professionals.

Licensed Practical Nurse (LPN). A person licensed under and providing health services within the scope of Minnesota Statutes, section 148.211.

Long Term Care Consultation Services (LTCC). LTCC provides assistance to people with long term or chronic care needs. Mandated assessment and services planning in state statutes provided to all citizens. The process of screening and assessment of an individual applying for nursing home admission or home and community-based services is part of eligibility determination for publicly funded long-term care.

MA. Medical Assistance (also known as Medicaid or Title XIX of the Social Security Act).

Managed Care Organization (MCO). An entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is: (1) a Federally Qualified HMO that meets the advance directives requirements of 42 CFR 489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR 438.116, section 2.37. All Minnesota MA/Minnesota Care health plans meet MCO requirements. *In MN, MCO serving Medicaid enrollees are currently all non-profit organizations.*

[MAXIS](#). The online computer system which records the data that determines a person's financial eligibility for various public programs.

[Medicaid](#). The national program which funds health care services to low-income individuals authorized under Title XIX of the Social Security Act.

[Medicaid Management Information System \(MMIS\)](#). A complex, highly integrated claims payment, information management, and retrieval system implemented in June, 1994.

[Medical Assistance \(MA\)](#). Minnesota's state plan program which funds health care services under the provisions of Title XIX of the Social Security Act and Minnesota Statutes, Chapter 256B.

[Medically Necessary](#). A term used to define criteria for approval of certain services or items. Listed in the MN Rule part 9505.0175 (Rule 47).

[Medicare](#). The national program which funds health care services authorized under Title XVIII of the Social Security Act for certain Social Security beneficiaries (aged, disabled, certain dependents).

[Minnesota Eligibility Technology System \(METS\)](#). Minnesota Eligibility Technology System is the public health portion of MNSure. MNSure is the online health insurance exchange the state developed under the Affordable Care Act. Applicants use MNSure to obtain health care coverage through the state's public health care programs, including Medical Assistance and MinnesotaCare.

[MinnesotaCare \(MNCare\)](#). MnCare is a publicly subsidized health care program for Minnesotans with low income who do not have access to affordable health care coverage. Members obtain health care service through a health plan.

[Minnesota Health Care Programs \(MHCP\)](#). The collective term for Minnesota's various health care programs: Senior Drug, Minnesota Senior Health Options, Medical Assistance, Prepaid Medical Assistance Program, General Assistance Medical Care, MnCare, and for purposes of this manual, the Alternative Care program.

[Minnesota Health Care Programs Provider Manual](#). Sometimes referred to as the MA billing manual. Used by providers for claims and billing information. Located on the DHS webpage under eDocs.

[Minnesota Senior Care Plus \(MSC+\)](#). A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and older.

[Minnesota Senior Health Options \(MSHO\)](#). A program offered by the Minnesota Department of Human Services and health plans for seniors eligible for both Medicare and Medical Assistance and also provides Elderly Waiver services.

[Moving Home Minnesota \(MHM\)](#). MHM is the rebalancing demonstration project to encourage the transition of eligible persons by improving the transition process from a qualified institution to community living through increasing outreach and decreasing barriers to transition.

[Nursing Facility Resident](#). A person admitted to a nursing facility for 30 or more days.

[OBRA Level I](#). The term used to describe one of the activities included in preadmission screening and required under state and federal law to occur prior to any admission to certified nursing or boarding care facility. A Long Term Care Consultant uses a series of questions to “screen” individuals for the presence or possible presence of mental illness or developmental disability, and makes referrals to other qualified professionals on the basis of the result of this screening. This screening and necessary referrals are also required as part of LTCC community assessments.

[OBRA Level II](#). The activities carried out by other qualified mental health or developmental disabilities professionals at referral under OBRA Level I. These professionals further evaluate and make determinations about mental illness or developmental disability, including recommendations for specialized services and psychiatric or ICF/DD level of care.

[Prior Authorization](#). The method of pre-authorizing Medical Assistance, extended waivers, Essential Community Supports, Moving Home Minnesota, and Alternative Care funding of certain restricted health care services before service payment or purchasing.

[Person Master Index \(PMI\) Number](#). The number permanently assigned to an individual for identification in MMIS. Also called “Recipient ID” or “Person ID”.

[Preadmission Screening](#). A federally mandated process for all persons entering a certified nursing or boarding care facility to screen for mental illness or developmental disability and determine the need for nursing facility level of care.

[Prepaid Medical Assistance Program \(PMAP\)](#). PMAP is Minnesota’s Managed Medicaid Program for Medical Assistance recipients. State and federal funds jointly fund this program. It is the largest of Minnesota’s publicly funded health care programs providing coverage for an average of 900,000 people each month. Various PMAP programs enroll children, families, single adults, people age 65 or older, and people who have disabilities.

[Primary Caregiver](#). The person designated by the individual as having the main role in providing informal care. A primary caregiver may be a family member, relative, friend,

neighbor or other person who agrees to provide routine care and assistance to the individual without reimbursement for the services and who, with the case manager and other providers, assists in assuring that services provided as specified in the individual's care plan.

Public Health Nurse. A nurse who is qualified as a public health nurse under the Minnesota Nurse Practice Act.

Reassessment. The face-to-face reevaluation of an Elderly Waiver or Alternative Care person's eligibility for these programs, including a reassessment of health status and need for services. It must be completed at least once a year or whenever the person's health or needs change significantly.

Recipient. A person determined to be eligible for Medical Assistance or other Minnesota Health Care Program.

Registered Nurse (RN). A person licensed under Minnesota Statutes, section 148.211.

Relocation Services Coordination (RSC). A "state plan" service available to MA recipients of all ages for up 180 days to carry out activities such as planning for, locating, and arranging services and supports needed to permit a person to return to community settings after institutional admission.

Representative. A person appointed by the court as a guardian or conservator or a person designated to have power of attorney or a durable power of attorney, or a person authorized by the person under Minnesota rules part 9505.0015, subpart 8.

Residence. The person's established place of abode.

(LTC) Screening Document. The document that records in MMIS the outcome of a screening and assessment, or case management activity carried out under the HCBS programs. This document used for community, nursing facility, telephone screenings, health risk assessments (HRA), and the refusal of the health risk assessment.

Service Agreement. The document that is entered on-line into MMIS which identifies services, providers, and payment information for a person receiving home care, waiver, Essential Community Supports, Moving Home Minnesota, or Alternative Care services. The on-line service agreement allows providers to bill for approved services and allows DHS to audit usage and payment data.

Social Worker (SW). An individual who meets the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota and who is employed as a social worker by a county.

Special Needs BasicCare (SNBC). A voluntary managed care program that provides Medicaid services and /or integrated Medicare and Medicaid services to Medicaid eligible people with a SSA or SMRT certified disability who are ages 18 through 64. This program is available in all counties provided by six different health plans. People receiving home and community based waiver services or state plan PCA/HCN services are eligible for SNBC, however, these services will continue to be paid fee-for-service, the health plan is responsible for all basic state plan services costs. Please see the SNBC brochure DHS-6301 on eDocs.

State Plan. The document which defines Medical Assistance services provided by the State of Minnesota under Title XIX of the Social Security Act for which the state receives federal financial participation (FFP). These services represent the “benefit set” for all persons with Medical Assistance.

Transaction Control Number (TCN). The unique 17-digit number assigned to each claim for identification purposes.

Visit. For purposes of MA home care, a visit is a unit of service.

Waiver Plan. The plan to offer waived services submitted by the state to, and approved by, the Center for Medicare/Medicaid Services (CMS) which allows the state to receive federal financial participation for home and community-based services authorized under the Code of Federal Regulations, title 42, part 441, subpart G.

Waivered Services. Services defined and funded by the waiver programs such as respite, homemaker, or companion services, and extended MA home care services provided under the waiver service plan. Other waiver programs not described in this manual may differ in services. These services are available only to persons determined to be eligible for a waiver program. Minnesota’s waiver programs are:

- Brain Injury (BI)
- Community Alternative Care (CAC)
- Community Access for Disability Inclusion (CADI)
- Developmental Disabilities (DD)
- Elderly Waiver (EW)

Chapter One

101.01 Introduction to MMIS

MMIS is the acronym for Medicaid Management Information System and implementation of the current system was in June 1994. It is the largest public health care payment system in Minnesota storing three years of online billing history.

The Medicaid Management Information Systems (MMIS) is comprised of several integrated subsystems that are used to process health care claims and payments to

providers and managed care capitation payments to the DHS-contracted managed care organizations. MMIS is the system of record for provider, authorization, third-party liability and payment data. The federal government reimburses DHS at a rate between 75 percent and 90 percent of the cost of MMIS operations, maintenance and development.

The system incorporates:

- HIPAA-compliant, standard national billing formats to increase uniformity with other Minnesota health care payers.
- A web-based MN-ITS “front-end” system to enable providers to determine recipient eligibility, submit claims, obtain claim status and get their remittance advice free and online. More than 99 percent of MHCP non-pharmacy fee-for-service claims are submitted electronically via MN-ITS.
- Phone-based, batch and real-time eligibility verification systems.
- A pharmacy point-of-sale system to enable prompt, electronic processing of 99.9 percent of all drug claims.
- Interfaces with METS, MAXIS, PRISM and the Social Service Information System (SSIS), to feed nightly into the DHS Data Warehouse to ensure that claims and payment information incorporate into DHS reports and decision-making.

The MMIS is composed of various subsystems, including:

Claims

This subsystem processes payment or denial of health care claims for services provided through public programs, with all other subsystems supporting it. In fiscal year 2017 MMIS processed approximately 37 million fee-for-service claims, 50 million encounter claims, and 28 million capitation payments to managed care providers. DHS paid almost \$11.7 billion to more than 69,000 providers, counties, tribes, and managed care organizations. Medical claims are received through an electronic mailbox system called MN-ITS. Drug claims are also received using “point of sale” software which returns an immediate approval/denial message to the submitting pharmacy or pharmacy biller.

Recipient

In 2017, approximately 1.496 million persons receive services through Minnesota Medicaid, MinnesotaCare, and state-funded health care programs. The Recipient Subsystem contains recipient health care program eligibility determination for both state supervised and county administrated programs such as Medical Assistance, MnCare, Alternative Care, etc. Financial eligibility for most public programs is determined through MAXIS for seniors and people with disabilities. Other populations may use METS for determining health care eligibility. Information transfers from state and county financial workers or from MAXIS or METS systems.

Provider

This subsystem maintains provider eligibility information for the 236,000 providers enrolled in Minnesota who provide services to persons participating in public programs.

Types of data include demographics, licensing information, and approved or restricted services. Also identified is case manager information.

Reference

Often referred to as the PDDD, this subsystem contains all of the necessary information regarding procedure codes, diagnosis codes, drug codes and DRG codes. For example, a procedure code record includes the code, a description, restrictions (age, gender) and the dollar amount MMIS will pay someone for providing that service. It also includes an indicator as to whether or not a procedure requires prior authorization.

Prior Authorization

The purpose of this subsystem is the processing and identification of those services authorized by case managers, DHS staff, or DHS contractors prior to payment to a provider. Programs that use prior authorization are: MA Home Care, Waivers (BI, CAC, CADI, DD, and EW), Moving Home Minnesota, Essential Community Supports, Alternative Care, MA Prior Authorization (Dental, Medical, Pharmacy, and Supply), Day Training and Habitation (DT&H) Non-waiver Pilot Program, and Insurance Extension programs. Authorization of some medical transportation through MTM. DHS also contracts with an external pharmacy review organization to approve pharmacy prior authorizations, and a medical review agent for the remaining authorizations.

Quality Control

Department of Human Services' (DHS) staff can only access this subsystem. It initially designed to meet the federal requirement to review a sample of all claims paid to determine under- or over-payments. This federal requirement was mandatory for a period of one year as a condition of system certification. Currently, this subsystem runs a monthly sample of claims to review for provider billing and/or claims examiner pricing errors. Generally, it provides an audit of MMIS.

[SIRS Summary Profile](#), [SIRS Treatment Analysis](#), [SIRS Claim Detail](#)

The primary purpose of the Surveillance and Integrity Review Section is the development of exception reports regarding provider and recipient data which compare claims to determine if there are areas that need further review.

Data Security

Mainframe software (ACF2) and application software written specifically for MMIS controls access to MMIS information. ACF2 prevents unauthorized access to the "front door" of MMIS, while the application security prevents unauthorized access to specific data elements or screens. MMIS security staff work with security liaisons located in each lead agency and DHS divisions within central office to ensure access when needed.

MARS

Contains the reports required by the federal government. Only DHS staff has access to this subsystem. The MARS subsystem produces the reports and files required by Centers for Medicare and Medicaid Services (CMS).

Financial Control

The Financial Control subsystem gives staff the ability to create and update “obligations”, post receipt entries, post reimbursement requests and track financial obligation activity. Obligations include both payment and collection liabilities of DHS, the county, and individuals. County workers or DHS Central Office staff create or change obligations. This subsystem has interfaces with the MMIS Third Party Liability (TPL) Resource file, Recipient File, Provider File, Claims Processing File, Medical Assistance Reporting System (MARS), and a daily Recipient File.

Third Party Liability (TPL)

This subsystem has two selections: TPL Billing Application and TPL Resource File Application. The TPL Billing Application used by Benefit Recovery to collect recovery payments on paid claims with possible third party liability. Also, to maintain insurance carrier information for billing and reporting to providers.

The TPL Resource File Application is used to “cost avoid” and/or “pay and close” medical claims submitted by providers. This subsystem records third party liability information for Minnesota Health Care program participants. County financial workers can add or update the information. MMIS recovered or cost avoided a total of \$960.7 million in 2017 by ensuring that liable third-party payers paid for health care before using state and federal funds.

Drug Rebate

This subsystem conducts a monthly download of utilization data for drugs reimbursed by Medicaid. MMIS also creates quarterly drug rebate invoices by combining the utilization data with unit rebate amounts furnished by CMS. These invoices mailed to manufacturers by DHS Drug Rebate staff. Tracking of payments and resolution of disputes is not one of its functions.

Managed Care

This subsystem supports the processing of capitated payments to managed care organizations. It identifies provider, contract, and rate information.

Reports

There are thousands of reports generated by MMIS. These reports are stored and accessible through Infopac; a mainframe report distribution software. Infopac is set up to retain multiple iterations of each report, and can “section” a report by agency (such as county or health plan) to prevent one agency from viewing another agency’s section of a report. Reports generated by MMIS on a regular schedule depending on need: daily, bi-weekly, monthly, quarterly, annually or on request.

101.02 MMIS Interfacing with MAXIS

MMIS depends on MAXIS for person eligibility determination functions and maintenance of all person information. The Recipient Subsystem completes this interface. Some information entered into MAXIS by the financial worker transfers to MMIS. Other information is direct entered into both systems.

The Recipient Subsystem collects the information from MAXIS and controls person demographic or health care program eligibility determination for state supervised, county administrated programs.

MAXIS assigns the recipient's ID number (also called Person ID number or PMI) to each person applying for most programs. It is a unique eight digit lifetime number that identifies the person in the system. This ID number does not change when the person changes programs, loses eligibility, or moves to another lead agency. If assignment of more than one PMI number then one of the numbers is inactive.

The PMIN Function assigns the PMI number when there isn't a financial worker involved in the person's case. Examples are those people screened through the preadmission screening program and not receiving services through a public program, or those people receiving services through the Essential Community Supports, or MNCare programs who are not eligible for services through any other type of public program. If an ID number obtained through the PMIN Function, then any changes to the birth date, name, and marital status uses the PMIN Function without the assistance of a financial worker. The information automatically transfers to MMIS.

Data produced in MAXIS and changed in MAXIS. If MAXIS provided incorrect information, the financial worker must correct the information in MAXIS. The change transfers to MMIS.

101.03 MMIS Access and Security Features

Their supervisor and the MMIS security officer in each agency determine assignment of the MMIS logon ID and security group. The security group will control access and actions to subsystems through the Main Menu Screen.

The security liaison submits a request to the MDHS for the logon ID to gain access to MMIS. This person will also contact the department for suspended logon IDs due to password violations, terminated access due to no activity within 45 days, or assignment of a temporary password. Please view Session 2 of the [MMIS Training Series](#) for more information on how to log into the system and use your password, as well as how to add MMIS to your computer or laptop. Use this link to download [BlueZone](#).

101.04 Prior Authorization Subsystem Overview

The Prior Authorization subsystem processing involves the entry, maintenance, and approval of these documents:

- Designated medical services, dental services, drugs, and supplies covered by the Medical Assistance (MA) program.
- Home care authorizations for state plan services.
- Screening documents for community, nursing home, waiver, Alternative Care, Essential Community Supports, Moving Home Minnesota, health risk assessments, and the MA Home Care programs.
- Service agreements for persons who are eligible for the above programs as well as the Day Training and Habilitation (DT&H) services (non-waiver pilot program), Special Needs services (Rule 186 funding), and the Insurance Extension Program.
- Health Risk Assessment documents for the Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC) programs.

101.05 Recipient Subsystem Overview

The primary objective of this subsystem is to identify all persons eligible for Minnesota Health Care Programs. In addition, those screened or assessed through the Long Term Care Consultation Services Program.

This subsystem is the source of all eligibility determination data for MMIS, whether generated by DHS public assistance programs, the Social Security Administration, the Department of Health, or MAXIS. It supports claims processing, management and administrative reporting, surveillance and utilization review reporting, and third party liability processing. It is also responsible for maintaining person benefit limits, controlling the buy-in process, and generating various reports.

Person eligibility, program, and demographic data obtained from the Department of Health, screening documents, the Children's Health File, and MAXIS.

Updates to the Recipient Subsystem provided on a daily basis from MAXIS. Information updated in the Recipient File used for service agreement editing to ensure eligibility continues.

The Recipient Subsystem maintains a single record for each person. Waiver, Essential Community Supports program and Alternative Care eligibility history is created and maintained by using information from the LTC or DD screening documents. The information obtained from the screening document is:

- Waiver program eligibility. Includes program type, eligibility begin and through dates, and last screening action date on the RWVR screen.
- Case manager. Includes case manager, certified assessor, and care coordinator name, number, and begin and end dates on the RMGR screen.

- Alternative Care and Essential Community Supports program eligibility. Includes the eligibility begin and end dates as well as the county of financial responsibility on the RELG screen.
- Medicare/MBI program eligibility. Includes the spans for persons eligible for Medicare/MBI Parts A and/or B on the RMCR screen.
- In addition, the Alternative Care and Essential Community Supports screening document updates the Recipient Subsystem with the person's mailing address on the RCAD screen. This screen shows the current home address, the last previous home address (if any) and any alternative mailing address and accessed by finding the case number as instructed below.

Case File – Person's Addresses

The Case information is different from the Person information. You are able to view case information on everyone connected to the case record as well as the person's home address and mailing address.

A case number is different from a PMI. The PMI number is person specific, however, all persons within a household share the same case number -- it is what links individual PMI's together as being somehow related.

Steps to locating a person's case number:

- Enter into the Recipient subsystem using the PMI number to find the case number field on the major program span of either the RSUM screen or the RELG screen.
- Write down the person's case number, and then use the PF6 key to return to the Key Panel screen.
- Move your cursor to the CASE NUMBER field in the second section of this screen, and enter the case number you wrote down. Press your keyboard key to move to the next screen
- You should now be on the RCAD (Recipient Case Address) screen. This screen shows the residential address with the current address displayed on the left side. The previous address is on the right side. The Medical Mailing Address section identifies an optional mailing address.
- Use the PF3 or PF6 key to return to the Key Panel screen.

Accessing and Viewing Data in the Recipient Subsystem

Session 5 of the [MMIS Training Series](#) explains how to log into this subsystem, navigate to the screens, read data that may cause edits to post on screening documents and service agreements as well as an explanation of different screens

101.06 Provider Subsystem Overview

This subsystem provides comprehensive provider related information on all providers enrolled to support claims processing, management reporting, and surveillance and

utilization review functions. It supports the processing of online provider enrollment applications and information changes.

There are many types of providers. Here is a list of their numbers and titles:

APACUPUNCTURIST
B1.....BIRTH CENTER
C1.....CERTIFIED PROFESSIONAL MIDWIFE
DC.....ALCOHOL AND DRUG COUNSELOR
E1.....EIDBI EARLY INTENSIVE DEV/BEHAVE INTER
HD.....HEALTH CARE DELIVERY SYSTEM
PR.....PSYCHIATRIC RESIDENTIAL FACILITY
RC.....RECOVERY COMMUNITY ORGANIZATION
00NURSING FACILITY
01HOSPITAL
02HOSPICE
03INSTITUTION FOR MENTAL DISEASE
04RENAL DIALYSIS FREE STANDING
05ICF/MR - FACILITY
06CHILDRENS RESIDENTIAL SERVICES
08NF CONTROLLING ORGANIZATION
09SCHOOL DISTRICT
10COMMUNITY MENTAL HEALTH CENTER
11REHABILITATION AGENCY
12SERV FOR CHILDREN W/HAND CLIN
13SERV FOR CHILDREN W/HAND PROV
14SOCIAL WORKER-LICENSED IND
15LICENSED DIETICIANS AND NUTRITIONISTS
16CHILD AND TEEN CHECKUP CLINIC
17REGIONAL TREATMENT CENTER
18HOME AND COMMUNITY SRV PROV.
19DAY TRAINING & HABILITATN CTR
20PHYSICIAN
21CONSUMER DIRECTED CARE
22AMBULATORY SURGERY CENTER
23CASE MANAGER (WAIVER)
24PRE-PAID HEALTH PLAN PROVIDER
25MARRIAGE AND FAMILY THERAPIST
26MENTAL HEALTH REHAB SPECIALIST
27MANAGED CARE HEALTH COODINATORS
28EDI TRADING PARTNER
29OCCUPATIONAL THERAPY
30DENTIST
31DENTAL HYGIENIST
32INDEPEND DIAG TESTING FACILITY
33CONSOLIDATED RECORDS (multiple legacy provider records)
34BILL ENTITY FOR MENTAL HEALTH

35OPTOMETRIST
36PODIATRIST
37CHIROPRACTOR
38PERSONAL CARE PROVIDER
39REGISTERED PHYSICAL THERAPIST
40SPEECH PATHOLOGIST
41LIC PSYCHIATRIC PRACTITIONER
42PSYCHOLOGIST
43AUDIOLOGIST
44COUNTY APPROVED CASE MNGR
45COUNTY RESERVATIONS SRVC
46APPROVED DAY TREATMENT CENTER
47CNTY CNTRCT MNTL HLTH REHAB SV
48REGIONAL SERVICES SPECIALIST
49BILLING ENTITY FOR PHYSICIAN SVCS
50INTENSIVE RESIDENTIAL TREATMENT SERVICES (IRTS) MENTAL HEALTH
51INDIAN HEALTH FACILITY PROV
52FEDERALLY QUALIFIED HLTH CTR
53RURAL HEALTH CLINIC
54FAMILY PLANNING AGENCY
55COMMUNITY HEALTH WORKER
56DENTAL LAB
57PUBLIC HEALTH CLINIC
58COMMUNITY HEALTH CLINIC
59COORDINATED CARE DELIVERY SYSTEM
60HOME HEALTH AGENCY
61PUBLIC HEALTH NURSING ORG
62CHEMICAL DEPEND FREE STANDING
63LICENSED PROFESSIONAL CLINICAL COUNSELOR
64PRIVATE DUTY NURSE
65NURSE PRACTITIONER
66NURSE MIDWIFE
67CERT REGISTERED NURSE ANESTH
68CLINICAL NURSE MENTAL HEALTH
69PHYSICIAN ASSISTANT
70PHARMACY
72TRANSPORT-BROKER
73WIC PROGRAM
74HEAD START PROGRAM
75OPTICIAN
76MEDICAL SUPPLIER
77HEARING AID DISPENSER
78OTHER NON-PHYSICIAN
79OTHER NON-TRADITIONAL
80LABORATORY, INDEPENDENT
81X-RAY/DIAGNOSTIC

- 82MEDICAL TRANSPORTATION PROV
- 83LIEN HOLDER
- 84STATE DEPARTMENT OF HEALTH
- 85STATE DEPT OF HUMAN SERVICES
- 86HEALTH CARE FINANCING ADMIN
- 87CO-PAY PROVIDER
- 88MCRE/MA ACCESS SERVICES
- 89SPECIAL CONTRACT PROVIDER
- 90INDIVIDUAL
- 91EMPLOYER
- 92GROUP PAYER
- 93MANUFACTURER PHARM/MED SUPPLY
- 94MEDICAL REVIEW AGENT
- 95CLEARINGHOUSE
- 96LICENSING AGENCY
- 97INSURANCE COMPANY
- 98BILLING INTERMEDIARY

The Provider Eligibility and Compliance Unit approves HCBS provider enrollment applications. Until this process is completed and the provider is in an active status, edits will post on any service agreement line item using this provider's number.

A provider may receive the following types of letters from the Provider Eligibility and Compliance Unit:

- 1) An approval letter when adding a new provider in an active status, a record changes from pending to active, or when adding a new service to the record. Along with an approval letter, the new provider will receive a packet which consists of a welcome letter, the provider manual, a supply of claim forms and the appropriate billing instructions.
- 2) A denial letter when a provider is determined to be ineligible, or when a providers' enrollment status changes from pending to denied.
- 3) A reinstatement letter when an existing provider changes from a terminated status to a renewal status.

Termination letters:

- A provider's status is changed from active to terminated;
- Changes to the record to "terminated - no claims activity" status due to no claims activity in twelve months. Providers are not deleted from the Provider File and may request reinstatement; or
- Suspension of the license of a Medical Assistance provider. The Provider Eligibility and Compliance Unit receives a list of license suspensions from HCFA and the Medical Review Board on a monthly basis.

Case Manager/Care Coordinator/Certified Assessor Provider Number

Assignment of a provider number to every county or tribal case manager used to identify that the person is case managing the care plan. Use of this number is on the screening document and on the ASA1 screen of the service agreement. However, not used on the line item for case management services.

Lead agency staff with the appropriate security will enter information on the PADD screen of the provider subsystem to obtain a new case manager nine-digit provider number under provider type 23. Do not include the case manager number on the screening document or service agreement until the status changes from "pend" to "active - no pay".

Care Coordinator Provider Number Type 27

Identify contracted county staff with health plans to provide care coordination activities for waiver persons enrolled in managed care, as well as care coordinators employed by health plans or from delegated agencies who have health plan contracts on the screening documents and service agreements as a care coordinator – provider type 27. In some cases, this will be in addition to their provider number type 23 as a county/tribal case manager. Assignment of one provider number 27 even if the care coordinator contracts with more than one health plan.

Creating a New Provider Number Type 23 or 27

- 1) Select the "PROVIDER FILE APPLICATION" from the Main Menu screen
- 2) On the Provider Key Panel (PKEY) screen, enter an "A" in the ACTION CODE field
- 3) On the PADD screen, enter the following information:
 - PROV TY (Provider Type) is either 23 or 27
 - SSN is a required field; this is a federal requirement; the social security number field is not viewable by others except by DHS provider eligibility and compliance staff, as needed; it is used for numerical comparison only
 - NAME is the case manager's name, first, MI, last
 - PRAC ADDRESS is the business name (i.e., Minnesota Co Human Services)
 - CORR DATE RECD (request date, if able to get in to this field)
 - Line (1) is the street address. This needs to be the physical address, not just PO Box
 - City, state, zip
 - TEL is case manager's business phone number with area code (do not use dashes in between any of the numbers). NOTE: it is important to keep this field updated. The phone number will be added to the recipient and provider service agreement letters and any other documents as needed
 - CNTY is the county code number preceded by a zero (3-digits)
 - TYPE PRAC field enter 01
 - FAX is a number that is accessible/used by the case manager
 - APP DT field is today's date

- SORT NAME is the case manager's name, it is entered last name first (phone-book style) – no punctuation
- 4) Note that the status is “pending”. Change provider type 23 to a status “3” in order to activate the UMPI Number. *You can also send a request to activate the number by emailing dhs_mhcp_provider_enrollment@state.mn.us.* Include the provider number, full name, agency name, and provider type. For provider type 27s, either contact the Provider Eligibility and Compliance Specialist at the above email or wait for the Provider Eligibility and Compliance Unit to receive a daily report showing new provider entries. They will activate the record. Until this is finished, do not use the care coordinator number type 27 on the screening document or service agreement or receiving reports in their MN-ITS mailboxes.
 - 5) Save your entry by using F3.

A message will appear on the screen when you use F3 if you are adding a duplicate person to the same agency who already has a provider type 23 or 27 number. This message is “Duplicate SSN found on Provider File. Provider = XXXXXXXX 00”. Review the number to verify that it is not a duplicate.

If a case manager (provider type 23) works out of more than one lead agency, they can have more than one provider number. If a case manager leaves one agency and receives a new number for a different agency, then later returns to the same agency, the first number is re-activated.

A Health Care Case Coordinator (provider type 27) can have *more than* one active UMPI at a time if they are working for more than one health plan.

A message will appear on the screen stating “Date of birth is required”. It is actually not required for these provider types. Hit F3 again and advance past it.

Another method to request a new provider number for type 27 is to complete the Health Care Case Coordinator – Provider Enrollment Application form [DHS-4474](#). Fax this form to (651) 431-7462.

Changes to the Case Manager PADD Screen

It is important to keep the case manager information current. The service agreement letters to the person and provider(s) show the name and phone number of the case manager listed on the PADD screen.

For provider type 23 UMPI* numbers:

If a case manager leaves the agency, the provider number is terminated by adding a new span for one of the below status and the effective date.

- H – Deceased
- J – Voluntary Termination

You may also contact dhs_mhcp_provider_enrollment@state.mn.us to request adding this termination type and date to the provider type 23 or 27 record. Include the NPI number, full name, agency name, termination date, and provider type in your request.

If a case manager, (provider type 23) changes agencies, they are required to obtain a different number for the new agency and the old number terminated by the original agency. When a case manager changes their name, change the name field and the Sort field on the PADD screen.

Contact the MHCP Provider Call Center at 651 431-2700 or 1-800-366-5411 for any changes needed for health care case coordinator (provider type 27 UMPI numbers)

How to Access the Provider Subsystem

There are several ways to access this subsystem.

- Use the F4 key on the CM/HP/CA NBR field located on the LTC screening document ALT1 screen, or the CM NBR field on the ADD1 screen of the DD screening document while in any action mode. Note: this method is not available for staff using health plan MMIS security groups.
- Use the F4 key while on the CM NBR field on the ASA1 screen or the PROV NBR field on the line item while in the service agreement in any action mode.
- Use the F5 key while in the LTC or DD screening document or the service agreement which brings up a screen to enter a provider name at the top, or a person's name at the bottom. Use the F4 key to view the Provider's Selection screen.
- Please see Session 4 in the MMIS Training Series for an explanation on how to use the PF keys. Session 16a explains how to navigate directly to the provider subsystem from the Main Menu screen and reviews several screens that can cause edits to appear on the service agreement.

101.07 Claims Subsystem Overview

Every other subsystem interacts by maintaining data necessary for claims processing, or by processing and/or reporting on the claims data created and maintained in those subsystems. Providers are encouraged to use the Eligibility Verification System (EVS) prior to submitting a claim. This telephone system identifies the person's eligibility for specific programs as of the time of the call.

This subsystem captures, controls, and processes claim invoice data from the time of initial receipt (on hard copy or electronic media) through final disposition, payment and application to the various claim files. Using the data contained in the most current recipient, provider, prior authorization and reference files, this subsystem will edit, audit, and process claims.

The claims subsystems maintains thirty six months of claims history for auditing, online inquiry and reporting purposes. Adjudicated (processed) claims prior to the 36 month retention period are stored permanently on the archived claims file. Claims requiring a

longer retention period to accommodate audit requirements or other needs maintained on the lifetime claims file.

Assignment of a 17 digit transaction control number (TCN) to batched claims provides a method of uniquely identifying any claim in the system. Claims are submitted electronically through MN-ITS.

A claim with errors is suspended and placed in the claims file where department staff attempted to resolve the claim exceptions. Claims deny if the problems cannot be resolved.

Once in the system, all claims are subject to a complete series of edits and audits to ensure that only valid claims for eligible persons and covered services reimbursed to enrolled providers. Edits applied to each claim include data validity, recipient, provider, reference, duplicate checking and utilization review auditing.

Claims adjudicate on a daily basis. A variety of pricing methodologies to accommodate the many claim types is used. To arrive at the final payment amount the system uses a fee schedule, DRG rate, or other method and subtracts applicable spenddown, co-payment, and third party payments.

Claim payment cycles typically occur on a bi-weekly basis. A remittance advice (RA) created for every provider with claim activity in a payment cycle. The RA organizes primarily by claim type and lists all claims processed in the payment cycle for the provider including paid, denied, and suspended claims. Gross adjustments and summary information are also included.

Adjudicated claims and paid/denied claims on the current month claims file and paid/denied claims on the claims history file are available for review by lead agencies using this subsystem. Claims display either in detail or in summary format with several claims per screen.

101.08 MN-ITS

The MN-ITS Eligibility Request or 270 transactions, is a web-based system designed to assist the provider in verifying eligibility for persons enrolled in MHCP by providing comprehensive recipient eligibility information, submit claims, obtain claim status, and get their remittance advice free and online. More than 99 percent of MHCP non-pharmacy fee-for-service claims are submitted electronically via MN-ITS. Assess the system via the internet. Access [MN-ITS](#) and then click Log in Here on the left navigation bar. Providers need to have a Username and Password to log into MN-ITS. They will be given a Username and Password upon registering for MN-ITS.

A provider will need the following information to utilize the MN-ITS Eligibility transaction:

- Date of Service; and
- The recipient's PMI number; or two of the three following pieces of information:
- Social Security Number

- Birth Date
- Last and First Name

The MN-ITS Eligibility Response, or the 271 transaction, provides the following categories of information:

- Major Programs and Spenddowns;
- Waivers;
- Other Eligibility Information (hospice, special transportation, co pays);
- Prepaid Health Plans;
- Designated Provider Services;
- Other Insurance;
- Medicare; and
- Benefit Limits

[101.09 Eligibility Verification System \(EVS\)](#)

Phone EVS is accessible by calling 651 431-2700 (press 7) or 800-657-3613. Access the system by using a push button phone with touchtone service. Providers will need their NPI/UMPI provider number to access data via the phone. Case managers can use their provider numbers.

Additionally, a provider will need the date of service and the recipient's PMI number or two of the three following pieces of information:

- Social Security Number
- Birth Date
- Last and First Name

The EVS provides the following categories of information:

- Major Programs and Spenddowns
- Waivers
- Other Eligibility Information (hospice, special transportation, co pays)
- Prepaid Health Plans
- Designated Provider Services
- Other Insurance
- Medicare
- Benefit Limits

Chapter Two

201.01 Purpose of the LTC Screening Document

Some form of the Long Term Care Screening (LTC) Document form DHS-3427 has been in use since 1984. Use this form to document preadmission screening, long term care consultation (LTCC) activities and Elderly Waiver (EW) program eligibility. Type L on the MMIS Key Panel Screen, and on the MMIS Selection Screen identifies this document. Sessions 6 and 7 of the [MMIS Training Series](#), introduces the LTC screening document and the steps in MMIS to view saved screening documents.

Long Term Care Consultation and Relocation Services Coordination

Each lead agency is responsible to perform certain activities under Minnesota Statutes 256B.0911 (Long Term Care Consultation). In addition, health plans perform other activities related to Relocation Services Coordination and Health Risk Assessments by visit recorded on the Health Risk Assessment form DHS-3427H.

Nursing Home Telephone Screenings

The LTC telephone screening document form DHS-3427T records the completion of preadmission screening of all persons entering a certified nursing or certified boarding care facility, before admission, to determine the appropriateness of the institutional placement as required under Minnesota Statutes, 256.975 (PAS), MN Statue Section 144.0724, subdivision 11 , and under federal OBRA legislation (Public Law 101 and 103).

Services Authorization and Payment

The LTC screening document provides an important link between assessment and eligibility determination, person information, and services authorization and payment. It plays a vital role in the processing and acceptance of the Elderly Waiver service agreement.

A service agreement authorizes Elderly Waiver services for a member eligible for the waiver and enrolled with South County Health Alliance. A service agreement authorizes Essential Community Supports (ECS) services for all members eligible for these services from any health plan. These service agreements permits payment to providers from the MMIS Claim subsystem.

An open major program MA eligibility span supports the service agreement. The approved screening document develops the waiver eligibility span. Information from the LTC screening document checks against eligibility information in the Recipient Subsystem that limits the length of services approved, the type of service agreement that can be entered, and the types and amounts of services that can be approved.

Payment of LTC and NF Services

Because form DHS-3427T plays a critical role in establishing payments for a variety of long term care services, including nursing facility services, assure timely submission of the LTC screening document information into MMIS. DHS recommends that no more than fourteen (14) calendar days lapse between completion of any LTCC or case management activity and the submission of the data into MMIS.

Data Collection, Quality Assurance, and Management Reporting

Finally, information from the LTC and HRA screening document in combination with other data by the Department of Human Services provides for a variety of program evaluation purposes, including quality assurance and management reporting.

201.02 Major Activities Utilizing the LTC Screening Document

Health plans use the LTC screening document to record:

- Intake and referral activities undertaken by the LTCC team;
- The completion of OBRA Level I screening for the presence of mental illness or developmental disability before admission as required under federal OBRA requirements mandates an OBRA Level II referrals for more thorough evaluations of persons identified under the Level I screening process;
- Eligibility for the EW program based on need for institutional level of care, as well as the ECS program for those members who lost their nursing home level of care by 1/1/15, and the authorization of these program services;
- Recommendations for services for persons screened or assessed, including institutional, formal, informal, or quasi-formal services;
- Lead agency activities including reassessment, termination from EW or ECS and program changes. A LTC screening document opens, extends, or closes EW or ECS eligibility on the Recipient subsystem. This does not affect Medical Assistance eligibility (only financial workers may open or close MA eligibility);
- Resource management to support services.
- Each health plan is responsible to perform certain activities under Minnesota Statutes 256B.0911 (Long Term Care Consultation).
- If a person chooses a community MHM service, a LTC screening document is entered into the MMIS with the MHM IND field = Y. Transitional plan development and coordination service claims then submitted to the health plan for payment.
- The bundle of services provided by the Customized Living Services provider.

201.03 Health Risk Assessments

Form DHS-3428H Minnesota Health Risk Assessment developed by DHS in 2018 to record health risk assessment information for members eligible for MSHO, MSC+, and the Special Needs BasicCare (SNBC) programs. For these programs, DHS-3428H records the required community individual's health risk assessment including ADL and IADL information at time of initial enrollment and when the member changes products or

health plans. This information is transferred to the HRA Screening Document form DHS-3427H for data entering into the MMIS.

Health plans may adopt this form or use it to develop their own form for assessments. Either way, complete all fields shown with an asterisk and enter into the MMIS screens ALT1 through ALT4 under Document Type H.

When a member refuses the health risk assessment, is not located, or there is a change of care coordination, this form is not completed but information from the HRA Screening Document DHS-3427H must be entered into the MMIS under Document Type H. See Section 201.06 on the mandatory fields for these actions.

Mailed Surveys

Locate DHS-3428H on the department's website under [eDocs](#). Use this form for HRA regardless if completed through telephone, mailed survey, or visit. The care coordinator should complete these fields before sending to the member:

- Name
- Recipient ID/PMI #
- Health Plan Reference Number (if any)
- Activity Type (use 01)
- Counties (COS, COR, CFR, and LTCC)
- Care Coordinator UMPI Number
- Assessment Team
- Assessment Result (use 35)
- Program Type

The Activity Type is 01 for mailed survey or telephone and the Effective Date of Assessment field is normally the same day as the member completed the form.

Online Entry

It is possible to download the form to your H drive or disc and used electronically to answer the fields. See the form's front page that identifies the correct Adobe Acrobat software, how to complete and save the form. Depending on the type of software you use, it is also possible to merge the fields to the Health Risk Assessment Screening Document Form DHS-3427H.

A health risk assessment is necessary at the initial contact after enrollment, on an annual basis, and if the member changes products or health plans. Complete MSC+, health risk assessments for those receiving Elderly Waiver services within 30 days of enrollment and persons in the community without EW within 60 days of enrollment. Complete all MSHO health risk assessments within 30 days of enrollments. Enter the document into MMIS. Enter HRAs conducted on or after September 1, 2017 into the MMIS before, during, or after the member is eligible for the waiver program. The screening activity type date can overlap with a waiver program if:

- The activity type is 01, 02, 05, or 07

- The activity type date is on or after September 1, 2017
- The assessment result is 35, 39, 50, or 98
- The program type is 18

Under these circumstances, the document type field on the MMIS Key Panel screen will be an "H". When these saved documents show on the MMIS Selection screen as type L-H. These HRA documents do not follow the same rules as the type L documents. Enter these documents in any date or assessment result order. There is no need to delete a type L document in order to delete a type H document. Do not delete a type L document before entering a type H document when the dates are out of order with each other. See Session 8b of the [MMIS Training Series](#) for Instruction on entering the HRA into MMIS.

201.04 Screening Document Fields

LTC Screening Document DHS-3427 and MMIS Screens ALT1 – ALT5

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
Section A and ALT1 Screen		
1	Person Last Name	System Entered
2	Person First Name	System Entered
3	Middle Initial	System Entered
4	PMI Number (Person Master Index)	Person's personal MMIS number. System Entered
5	Reference Number	To identify the individual by the agency's unique numbering system.
6	Date Submitted	System Entered. The date the screening document is entered and saved in MMIS
7	Birth Date	This field must match the birth date on the Recipient Subsystem.
8	Sex	System Entered
9	Referral Date	The date of original referral for screening or assessment.
10	Next NF Visit	The purpose of this field is to identify the date of the next annual visit for persons under age 65. The date that is populated is 1095 days after the activity type date of the most recent activity type 04. While the initial visit is mandatory, the annual visit delays up to three years. The automatically

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		populated field uses assessment result 43. It is a protected field.
11	Activity Type	Identifies the activity. See Session 7a of the MMIS Training Series for descriptions of all the activity types.
12	Activity Type Date	<p>This field plays many roles. Some purposes are:</p> <ul style="list-style-type: none"> • indicates the date the agency performed an assessment or administrative activity • is used in combination with the Referral Date for federal reporting on a timely assessment • sets the first day of the 60-day window allowed between the activity type date of activity types 02, 04, 06, 08, or 09 and the effective date when activity type 07 can be used to change the assessment result • is used to indicate ‘as of’ in the MMIS logic when new activity types are created • controls when activity type 08 for person turning age 65 on the BI, CAC, or CADI programs must be assessed
13	COS, COR, CFR	County of Service, County of Residence and County of Financial Responsibility. If there is a financial worker involved with the case, the manually entered information changes if not correct. COS refers to the county providing financial worker service for MA eligibility or re-determination. COR is where the person lives. For private pay and all others without financial workers, assume the COS, COR and CFR are the same (i.e. where a person lives).
14	LTCC County	<p>The county, tribal agency, or health plan who completed the screening or assessment.</p> <ul style="list-style-type: none"> • The county values are 001 – 087. • SLL = Senior LinkAge Line® Staff • White Earth tribal agency’s code is 0B2. • Leech Lake Tribal Band’s code is 0A4. • Fond du Lac tribal agency’s code is 0A2. • Mille Lacs tribal agency’s code is 088. <p>The health plan values are:</p>

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		UCM = A5658136 00 (UCare MN) MED = A4057139 00 (Medica) MHP = A9657134 00 (Metropolitan Health Plan replaced by HHP) BPH = A0658138 00 (Blue Plus) HPH = A5857139 00 (Health Partners) IMC = A1060139 00 (Itasca Medical Care) PWH = A1551183 00 (Primewest Health System) SCH = A0137073 00 (South Country Health Alliance)
15	Legal Representative Status	Records guardianship or legal representative status as determined by a court.
16	Primary Diagnosis	<p>The primary diagnosis that underlies the need for services and care. Identified on the service agreement letter for providers to use on their claim form if they wish.</p> <p>The following diagnosis codes for non-diagnosing providers may be used by assessors when a diagnosis from a medical record is unavailable:</p> <ul style="list-style-type: none"> • Z74.1 need for assistance with personal care • Z73.6 limitation of activities due to disability • Z59.0 homelessness • Z13.9 encounter for screening, unspecified • Z59.1 inadequate housing • R69 illness, unspecified • Z59.9 problem related to housing and economic circumstance, unspecified <p>Use the following ICD-10 developmental disability diagnosis codes on both the LTC and DD screening documents:</p> <ul style="list-style-type: none"> • F70 – mild intellectual disabilities • F71 – moderate intellectual disabilities • F72 – severe intellectual disabilities • F73 – profound intellectual disabilities • F78 – unspecified intellectual disabilities

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		<ul style="list-style-type: none"> F79 – other intellectual disabilities <p>Placing the cursor on any of the diagnosis fields and using the PF4 key will show you the name if the condition represented by the number.</p>
	Secondary Diagnosis	The secondary diagnosis that may affect the need for care or services. Also, see above.
18	Is there a history of a DD diagnosis?	Records if there is a history of a developmental disability or related condition diagnosis. (Y/N)
18A	If so, what is the diagnosis	Indicates the DD diagnosis. See the acceptable DD diagnosis codes listed under primary diagnosis.
19	Is there a history of a MI diagnosis?	Records if there is a history of a mental illness diagnosis (Y/N)
19A	If so, what is the diagnosis	Indicates the MI diagnosis. Use diagnosis codes obtained from medical records.
20	Is there a history of a BI diagnosis?	Records if there is a history of a traumatic brain injury diagnosis (Y/N)
20A	If so, what is the diagnosis?	Indicates the BI diagnosis. Use diagnosis codes obtained from medical records.
22	Case Manager/Care Coordinator/Certified Assessor Name	System Entered
23	Case Manager/Care Coordination/Certified Assessor NPI/UMPI Number	<p>The provider number of the county or tribal case manager assigned to the person. It is a provider type 23.</p> <p>In addition, enter here the provider number of the health plan coordinator for the MSHO, MSC+, and SNBC programs. It is a provider type 27.</p> <p>Placing the cursor on this number and using the PF4 key will show the name of the person and their location (on the PADD screen).</p>
Section B and ALT2 Screen		

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
24	Present at Screening/ Assessment	Identifies different types of people who were present at the screening or assessment. No duplicates allowed. NOTE: the County PAS Consult does not indicate that the second member of the team was physically present. It indicates that the consult occurred.
24a	Informal Caregiver	Answers if the person has an informal caregiver who provides regular services. An informal caregiver are family, friends, neighbors and others who provide services and assistance without reimbursement. These individuals do not need to be living in the same household as the care recipient to receive services or support under EW, AC, or ECS programs. The answer taken from field E.15 in form DHS-3428, or from field D.15 in form DHS-3428A. Y or N
25	Marital Status	Legal marital status
26	Reason(s) for Referral	Why the person or family is requesting a screening or assessment. Use up to two different values.
27	Current Living Arrangement	Whom the person lives with. Value 04 is a congregate setting.
28	Planned Living Arrangement	Whom the person will live with. Value 04 is a congregate setting.
29	Assessment Team	Identifies who completed the assessment or screening. Value 04 used with the CAC program.
30	Hospital Transfer	This field asks if the person admitted to a long term care facility (nursing or certified boarding care facility) from an acute hospital. (Y/N)
31	OBRA Screening Level 1	Was an OBRA Level 1 screening completed? (Y/N)
On ALT2 screen	Dental Concerns	For SNBC and MSHO/MSC+ health risk assessments. Values are Y, N, or C (choose not to answer). Field is on the form DHS-3427H.
On ALT2 screen	Have Dentist	For SNBC and MSHO/MSC+ health risk assessments. Values are Y, N, or C (choose not to answer). Field is on the form DHS-3427H.
32	Current Housing Type	The setting where the person lives. NOTE: Customized Living, 24 hour and Customized Living Services are not housing types.

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		Individuals receive services in a variety of housing types including licensed settings such as foster care, or setting with a physical plat license such as board and lodge, as well as in the person's apartment.
33	Planned Housing Type	The setting where the person will live. See above instructions.
34	Current Program License	The program license of the housing setting, where the person is currently living, if any. Foster care, or nursing facility, e.g. <i>This field is not mandatory as of July 2020.</i>
35	Planned Program License	The license of the housing setting where the person is planning to live, if any. Foster care, or nursing facility, e.g. <i>This field is not mandatory as of July 2020.</i>
36	OBRA Level 2 Referral	<p>Indicate "y" if a referral was required and made as determined through the Level 1 screening, or a Level 2 screening completed prior to the Level 1 screening.</p> <p>If the DD History field = Y, the OBRA Level 2 Referral for DD DX must be a Y. If the BI History field = Y, the OBRA Level 2 Referral for MI can be a Y or N.</p> <p>If the MI History field = Y, the OBRA Level 2 Referral for MI must be a Y for persons who meet the criteria for serious mental illness (SMI) that is defined on the MI Level 1 form DHS-3426 and who are being admitted to an NF or boarding care facility. Complete this Level II screening prior to the NF or boarding care facility admission.</p>
37	BI/CAC Referral	Indicates whether a referral was required and made according to BI and CAC program requirements.
Section C: General Function and History and ALT3 screen Fields 38 - 74	Activity of Daily Living (ADLs) Case Mix A – L and V* Disability Certification	Records information obtained during screening/assessment about the person's strengths and areas for support, and past health care utilization.

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
	Self-Evaluation Hearing Communication Vision Mental Status Evaluation Independent Activity of Daily Living (IADLs) Falls Hospitalizations – number within last year Emergency Visits – number within last year NF Stays – number within last three years Ventilator Dependent Family Planning Sexually Active	<p>The case mix letter checks for accuracy based on the combination of ADL values.</p> <p>*The Ventilator Dependent field values 02 and 03 allow the case mix to be V for EW persons. See more information at the end of this chart.</p> <p>Reminder: the Supplemental Form for Assessment of Children under 18 (DHS 3428C) is required for all persons under age 18. This form is a determination of age-appropriate dependences.</p> <p>See the Case Mix Classification Worksheet DHS form-3428B to determine the correct case mix value.</p> <p>See the Falls question at the end of this chart.</p> <p>The family planning and sexually active fields are on the health risk assessment screening document form DHS-3427H and completed only for the SNBC health risk assessments.</p>
Section D and ALT4 screen 75A and 75B	Assessment Results and Exit Reasons	<p>Field 75A: The outcome of the assessment activity. Choices are:</p> <ul style="list-style-type: none"> • 01 – used only once to initially open to the EW program • 02 or 03 – community assessment • 04 – 09 institutional screenings • 10 – changing from CADI or AC to EW • 11 – reopen to the same HCBS program that was exited in the past • 12 – used with activity type 10 • 13 –the annual reassessment visit during the EW program • 18 – the NF visit for conversion case management or relocation service coordination • 17, 20 – 25 - exiting from EW or ECS programs. With some exclusions, exit codes 17, 21 – 24, require the advance notice of

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		<p>appeal sent to the person. See more information about exit codes at the end of this chart.</p> <ul style="list-style-type: none"> • 29 – used in fields 78 – 80 • 30 – used in field 75B to indicate exit from EW was due to death • 36 – to record the member's choice of the CDCS option • 37 – to record the member's decision to end the CDCS option • 98 – used with 1) activity type 05 to record care coordinator changes; or 2) for fields 78, 80, and 81; • 99 – used in field 80 <p>Field 75B: When using an Exit Code (values 17 - 25) in field 75A to exit from EW or ECS, an Assessment Result Code 02 -11, 18, 30, or 98 must also be entered in field 75B to indicate what will happen to the member after leaving the program. Only use value 30 in field 75B when the Exit code is 24 or 25.</p>
76	Effective Date	<p>Effective date of the outcome identified in field 75A. This date begins the EW eligibility span, extends the span, and closes the span on the RWVR (waiver) screen in the Recipient Subsystem.</p> <p>It is used to edit against eligibility information in the Recipient Subsystem (LTC ineligibility, living arrangement, managed care enrollment, hospice period, major program)</p> <p>This date used to determine the correct case mix budgets for AC, ECS, EW, and CDCS.</p> <p>It establishes the age of the person assessed.</p>
77	Informed Choice	<p>This field indicates that the member received information about and understands their rights regarding a choice between institution and community services, their right to a choice in</p>

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		services and providers, and they signed the Community Support Plan, DHS Forms 2925, 4166, or 6791B. Provide this information to persons assessed for waivers and for other community assessments. This field must be a "Y".
78	Person Choice	The person's choice of services and setting.
79	Guardian Choice	The choice of the person's guardian, if any. Leave blank if there is no guardian.
80	Family Choice	The family's choice of services and setting for the person.
81	LTCC/IDT Recommendation	The assessor's recommended services and setting for the person. Do not use value 29.
82	Level of Care	<p>The assessor's determination of various levels of institutional need for care. For example, "NF Risk" indicates the person's need for the level of care a nursing facility provides.</p> <p>A person would meet the NF level of care if their planned living arrangement is 01, 05, or 06 and they have one of the following additional risks: vision or hearing impairment, or increased vulnerability for self-neglect or maltreatment by another, or a fall resulting in a fracture within the last 12 months.</p> <p>Note: Value 02 (NF/Certified Boarding Care) is describing two types of nursing facilities.</p>
	NF Track Number	This field is no longer used for activity type date of 11/1/13 or greater. Leave it blank.
83	Case Mix Amount	<p>The maximum monthly dollar limit that used for EW services. See the MMIS online Session 19 for the procedure to request EW conversion rates.</p> <p>DHS received approval from CMS to exceed the individual budget caps in the Elderly Waiver program in order to pay environmental accessibility adaptations (EAA) provided prior to the date of death or date of institution stays of 30 or more days. This also includes verified EAA authorized in the CDCS Support plan under the Environmental Modifications and Provisions service category.</p>

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		Please provide instructions to these providers for payment.
84	Reasons for NF Continued Stay/CDCS Ending	This field shows: 1) The reason(s) why the person remains in an institution after a relocation assessment is completed. Use up to two different values. 2) The reasons the person on EW ends the CDCS option. Use up to two different values.
	Relocation to Community	A field on the health risk assessment screening document form DHS-3427H and completed only for the SNBC health risk assessments.
Section E and ALT4 screen 85 – 100a	Professional Conclusions	Summary statements regarding the basis of “level of care” decisions as determined by assessors. Use Y or N. Field 100a is the question for the PCA Complex. It asks if the person assessed and found to be eligible for 12 hours or more of PCA services (Y or N).
Section F and ALT4 screen 101 – 103	Waiver/AC Eligibility Criteria	These fields verify meeting additional EW eligibility criteria. Use Y or N.
104	Program Type	Indicates which program, if any, will fund planned services. Use program type 18 for health risk assessments and full community screenings. Use program type 19 for face-to-face visits and telephone screenings in the nursing home. In addition, use for relocation service coordination (RSC).
105	MHM IND	Moving Home Minnesota. Add “Y” if person elected this program when screened in the institution. Document will remain in suspense and route to DHS for approval.
106	CDCS (Y or N)	An indicator of the CDCS option for the person on the EW program.
107	CDCS Amount	The monthly dollar cap for the CDCS services. It is system entered for EW.
108	Services	Mandatory for MSHO and MSC+ members receiving Elderly Waiver services. Required for

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		<p>reassessments (activity type 06 with Activity Type Date of 8/1/18 or later.</p> <p>The purpose is to identify if member is receiving one of these services. Values are AD (adult day), CL (customized living), FC (foster care) or NA (none). If a person has both adult day service and a residential service, choose the residential service provider for the evaluation. If answer is NA then don't complete the Provider NPI Number, Person, and provider's performance fields.</p>
109	Provider NPI Number	Mandatory for MSHO and MSC+ members receiving Elderly Waiver services. Required for reassessments (activity type 06) and the LTCC County field = MCO code. Purpose is to identify the number of the provider who is providing the AD, CL, or FC services.
110	Person	<p>Mandatory for MSHO and MSC+ members receiving Elderly Waiver services. Required for reassessments (activity type 06 and the LTCC County field = MCO code) and the Services field is not NA. Purpose is to identify if member:</p> <ul style="list-style-type: none"> • Is present and knows the provider is providing the services (value 1); • Does not know the provider provides these services and has a guardian/conservator to complete the questions (value 2); or • Does not know the provider is providing these services and has no guardian/conservator (value 3) <p>If answer is value 3, then protected fields from Respect to Housing on the ALT5 screen from data entry.</p>
<p>Section G and ALT5 Screen</p> <p>111</p>	Service Codes	Records formal services, informal care giving, quasi formal services and identifies the bundled services for Elderly Waiver customized living services. May have up to eighteen different selections.

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
		<p>(C) – EW customized living services provided by the CLS provider.</p> <p>(F) - Formal services are paid through funding sources such as the waiver, Alternative Care, Medical Assistance, Medicare, or private insurance.</p> <p>(I) - Informal services are unpaid services</p> <p>(Q) - Quasi-formal services require a small payment such as a stipend.</p> <p>(M) - Moving Home MN services</p> <p>(O) – Offered</p> <p>Update this section at any time using Activity Type 05 and assessment result 98.</p>
112 – 139	<p>These questions identify the provider's performance in implementing the member's service plan and supporting their desired outcomes.</p> <p>See the Person's Evaluation of Foster Care, Customized Living, or Adult Day Service form DHS-3428Q for the valid values. Also, see Session 9 of the MMIS Training Series for more information.</p> <p>These fields protected when the Services field</p>	<ul style="list-style-type: none"> • Respect (RSPT) • Privacy (PVCY) • Performance (PERF) • Response (REP) • Goal (GOAL) • Work (WORK) • Community (COMM) • Funding (FUND) • Quality (QUAL) • Recommendation (RECM) • Different (DIFF) • Adult Day Services (ADYS) • Day (DAY) • Time (TIME) • Food (FOOD) • Lease (LEAS) • Lock (LOCK) • Share (SHAR) • Decorate (DECO) • Visitors (VIST) • Access (ACCS) • Spaces (SPAC) • Housing (HOUS)

Field # from paper form DHS-3427 and MMIS screens ALT1 through ALT5	Field Name	Description
	is NA, the Person field is 3, or the Activity Type is not 06.	

Case Mix V – Assessment for Vent Dependency*

This case mix may be used by all waiver programs to identify an individual is ventilator dependent if the person receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days. Intermittent or PRN use of oxygen, use of oxygen monitors or apnea monitors only, nebulizer treatments or CPAP devices for snoring or sleep apnea do not fall under the definition of “mechanical ventilation for life support”.

*See DHS-3428B Case Mix Classification Worksheet to determine the case mix V. Responses coded 02 or 03 on the DHS-3428 or 3428A (Long Term Care Consultation Assessment) will allow the Elderly Waiver case mix budget for case mix V.

Falls Question

1. Have you experienced any falls? 00 ____ No 01 ____ Yes
 - a. If 1 = 01, go to 3.
 - b. If 1 = 00, go to 2.

2. If no, is there a concern about falling? 00 ____ No 02 ____ Yes
 - a. If 2 = 00, 00 is code for 3427.
 - b. If 2 = 02, 02 is code for 3427.

3. A fall with fracture in last 12 months. 00 ____ No 03 ____ Yes
 - a. If 3 = 00, 01 is code for 3427.
 - b. If 3 = 03, 03 is code for 3427.

Exit Descriptions

Do not exit the person from the ECS or EW program because they did not receive a service every month. Some services are not on a regular basis or only once. The program remains open for services needed at some point in the future. Exit from the program when all services are exhausted and no other future services anticipated.

Provide the Notice of Action forms [DHS-2828A](#) or [2828B](#) to the person.

Use these values when the person exits the ECS or EW program. **These rules apply to activity type dates October 1, 2019 or later.**

Exit Codes	Activity Type 06	Activity Type 07	Allow Retro Exit?	Advance Notice Needed?	Notes
17	X		N	Y	<p>When using activity type 06, the exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</p> <p>When using activity type 07, the effective date cannot be more than the last day of the month that follows the current month. Use for loss of eligibility for Medical Assistance</p>
17		X	Y	N	
20	X		N	Y	<p>The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</p>
20					
21	X		N	Y	<p>The exit effective date must be a minimum of 30 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.</p>
21					
22	X		N	Y	<p>When using activity type 06, the exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement when the exit reasons are not 04, 07 – 09.</p> <p>The effective date can be retro for activity type 07 when using exit reasons 04, 07 – 09 (facility admission) except for ECS (see exit</p>
22		X	Y (see note)	N (see note)	

Exit Codes	Activity Type 06	Activity Type 07	Allow Retro Exit?	Advance Notice Needed?	Notes
					reason 24). Advance notice is not required when using these exit reasons.
23	X		N	Y	The exit effective date must be a minimum of 10 and no more than 60 days in the future from the date the adverse action notice was mailed or given to the person to comply with the advance notice requirement.
23		X	N	Y	
24					Can be retro to the date of the event. For anticipated exit dates, the effective date can be no more than the last day of the month that follows the current month.
24		X	Y	N	
25					The effective date of the exit is typically the same date as the opening to the program.
25		X	Y	N	

17 – Person lost financial eligibility for current program. If the exit is due to Medical Assistance closure then use activity type 07. One example is if the person’s spouse dies and allocated income or assets transfers back to them making them ineligible for the EW program. The person may meet the AC financial thresh hold. *The person cannot open to AC by voluntary refuse to open to or remain on MA.*

When using Activity Type 07 the Effective Date cannot be more than the last day of the month that follows the current month.

20 – Person’s level of care **changed**. Change the level of care field to show the correct status at time of exiting. Use this code when exiting EW or ECS and the exit reasons are NF (04, 07 – 09). Activity Type 06 must be used to exit and change to the new level of care.

21 – Person meets no level of care criteria. Used only with Activity Type 06. Change the level of care (risk status) field to 07. The Effective Date must be at least 30 and no more than 60 days in the future to meet the advance notice requirements.

22 – Person no longer meets the program’s criteria other than financial or level of care. Examples are:

- The person admits to an institution (NF, etc.) for more than 30 days.
- The program services cannot reasonably meet the person's health and safety in the community. Contact the Adult Protection Services unit.
- There are other funding sources to pay for the services such as long term care insurance, Medicare, Medical Assistance, Title 3, or private pay.
- The person no longer needs the programs' services.
- The person is receiving GRH specialized services (not GRH housing) and so is not eligible for waiver services.
- The person is exiting the waiver and opening to home care program only.
- Exit from CADI to EW for 65th birthday

23 – Person chooses to leave the program.

24 – Person exited for reasons other than one of the other exit codes such as:

- Incarcerated
- Person cannot be located for reassessment visit
- Death (use code 30 in field 75b)
- Person moved out of state
- Exiting ECS to allow the Senior LinkAge Line® staff to enter the preadmission screening for nursing home admissions.

Use code 98 in field 75B unless reason is death then use code 30. The Activity Type must be 07.

25 – The program closes due to an error in opening, death, or for other reasons in which no waiver, AC, or ECS provided services. Decide to provide notice if the person refused services before they began. Using this code will remove the Elderly Waiver “slot” and delete the Elderly Waiver eligibility span from the RWVR screen. Only use with Activity Type 07. Put code 30 in field 75b if person has died. The effective date must be the same as the opening effective date.

26 – This code is not valid as of activity type date February 1, 2019 and later.

Recording Exits – Field 75b

Exit a person on the EW or ECS program any day of the month. When using an Exit code of 17, 20 – 25 to exit the person from the program, enter an exit reason into field 75B of the LTC screening document form. Use values 02 - 11, 18, 30, or 98 in field 75B to indicate the results of the person leaving the program. Use value 30 when the exit code is 24 or 25. Do not use reasons 04, 07, or 08 with exit code 21.

Advance Notice of Appeal

Provide the notice of appeal to the person for most exits. See the above chart for exceptions. This notice contains the rights to appeal the decision for reduced or services ending.

Use EW exit code 21 at least 30 days but no more than 60 days from the date the notice given or mailed to the person. For all other exit codes needing advance notice, the Effective Date of the exit is at least 10 days and no more than 60 days from when the notice given or mailed to the person. To allow this exit date in the future, the EW or ECS eligibility span will extend beyond the current eligibility end date if needed.

If the person appeals the program closure decision, reopen the program back to the exit date. Delete the exit screening document. If the person loses the appeal, close the program to the date of decision.

Do not provide the notice of appeal if the exit is retroactive. Such when notifying the care coordinator of an exit that occurred prior to the current date. Use activity type 07. The effective date may then be earlier than the activity type date.

[EW Program Types: Diversion vs. Conversions](#)

For purposes of coding the program type field, a diversion is a person who is not a resident of a long term care facility at the time of the assessment. A conversion is a person who was a resident of a long term care facility at the time of the assessment. A person who opens to a program under one of these types will remain that type until they exit the program.

If the person exits the program and later returns, it should be re-determined if they are now a diversion or a conversion.

For purposes of budgets payment, people who were residents of a facility for at least thirty days and enter the EW program may qualify for a monthly budget higher than those case mix budgets available for diversions or conversions with less than a thirty day stay. See section 201.14 for more details.

The below chart shows the fields for the health risk assessment form DHS-3427H.

[Health Risk Assessment Screening Document DHS-3427H and MMIS Screens ALT1 – ALT4](#)

Field from paper form DHS-3427H and MMIS screens ALT1 through ALT4	Field Name	Description
Section A and ALT1 screen	Person Last Name	System Entered
	Person First Name	System Entered
	Middle Initial	System Entered
	PMI Number (Person Master Index)	System Entered
	Reference Number	To identify the individual by the MCO's unique numbering system.

Field from paper form DHS-3427H and MMIS screens ALT1 through ALT4	Field Name	Description
	Date Submitted	System Entered. The date the screening document is entered and saved in MMIS
	Birth Date	This field must match the birth date on the Recipient Subsystem.
	Sex	System Entered
	Referral Date	The date of original referral for screening or assessment.
	Activity Type	Identifies the HRA activity. <ul style="list-style-type: none"> • telephone assessment or mailed survey Activity type 01 • face-to-face visit, Activity type 02 • care coordinator or housing change, Activity type 05 • case management activity when the member cannot be found or refuses to complete the HRA, Activity type 07
	Activity Type Date	The date the above activity occurred.
	COS, COR, CFR	County of Service, County of Residence and County of Financial Responsibility. If a financial worker is involved with the case, the information changes when incorrect. COS refers to the county providing financial worker service for MA eligibility or re-determination. COR is where the member lives. For private pay and all others without financial workers, assume the COS, COR and CFR are the same (i.e. where a member lives).
	LTCC County	The health plan who completed the screening or assessment. The values are: UCM = A5658136 00 (UCare MN) MED = A4057139 00 (Medica) MHP = A9657134 00 (Metropolitan Health Plan replaced by HHP) BPH = A0658138 00 (Blue Plus) HPH = A5857139 00 (Health Partners) IMC = A1060139 00 (Itasca Medical Care) PWH = A1551183 00 (Primewest Health System) SCH = A0137073 00 (South Country Health Alliance)

Field from paper form DHS-3427H and MMIS screens ALT1 through ALT4	Field Name	Description
	Case Manager/Care Coordinator/Certified Assessor Name	System Entered
	Case Manager/Care Coordination/Certified Assessor NPI/UMPI Number	The provider number of the health plan coordinator. It is a provider type 27.
Section B and ALT2 Screen		
	Assessment Team	Identifies who completed the assessment or screening. Use values 02 or 03.
	Current Housing Type	The setting where the member lives. This field is for SNBC members but available for MSHO/MS C+ HRA. If populated, complete the Current Living Arrangement too.
	Do you have a dentist?	Y, N, or C (choose not to answer)
	Dental Concerns	Y, N, or C (choose not to answer)
Section C and ALT3 Screen General Function and History Fields	<ul style="list-style-type: none"> • Dressing • Grooming • Bathing • Eating • Bed Mobility • Transferring • Walking • Behavior/Emotional (SNBC only) • Toileting • Self-Evaluation • Hearing • Vision • Phone Calling • Shopping • Preparing Meals • Light Housekeeping 	<p>Records information obtained during assessment about the member's strengths and areas for support and past health care utilization.</p> <p>Unless noted below, the fields will have these values for Activity Type Date 8/1/18 and greater:</p> <ul style="list-style-type: none"> • 00 – needs no assistance • 10 – yes, needs assistance, met by current supports or help from others or equipment • 11 – yes, needs assistance not met by current supports, help from others, or equipment • 12 – chose not to answer <p>Self-Evaluation answers are:</p> <ul style="list-style-type: none"> • 00 – no response • 01 – poor • 02 – fair • 03 – good • 04 – excellent <p>Hearing</p>

Field from paper form DHS-3427H and MMIS screens ALT1 through ALT4	Field Name	Description
	<ul style="list-style-type: none"> • Management of Medications/ Other Treatment • Insulin Dependent (SNBC only) • Money Management • Transportation • Falls • Hospitalization – total number within last year • Emergency Visits – total number within last year • NF Stays – total number within last three years • Do you have any family planning needs? (SNBC only) Y, N, or C (chose not to answer) • Are you sexually active (SNBC only) Y, N, or C (choose not to answer) 	<ul style="list-style-type: none"> • 00 no hearing impairment or impairment corrected with hearing aides • 01 – hearing difficulty at level of conversation • 02 – hears only very loud sounds • 03 – no useful hearing • 04 – not determined <p>Vision</p> <ul style="list-style-type: none"> • 00 – no impairment of vision or impairment corrected with glasses, contacts • 01 – has difficulty seeing at level of print • 02 – difficulty seeing obstacles in environment • 03 – no useful vision • 04 – not determined <p>Communication</p> <ul style="list-style-type: none"> • 00 – excellent • 05 – good • 06 - fair • 07 – poor • 08 – unable to answer • 12 – chose not to answer <p>The IADLS fields:</p> <ul style="list-style-type: none"> • Telephone Calling • Shopping • Preparing Meals • Light Housekeeping • Money Management • Transportation <p>will use the following values:</p> <ul style="list-style-type: none"> • 01 – needs no assistance • 10 – yes, needs assistance, met by current supports or help from others or equipment • 11 – yes, needs assistance, not met by current supports, help from others, or equipment

Field from paper form DHS-3427H and MMIS screens ALT1 through ALT4	Field Name	Description
		<ul style="list-style-type: none"> • 12 – chose not to answer <p>Medication Management</p> <ul style="list-style-type: none"> • 01 – need no help or supervision • 05 – do not take medications • 06 - only need someone to set up my medications • 07 – only need someone to remind me to take medications • 08 – need medication setups and reminders • 09 – need someone to help me take them • 12 – choose not to answer <p>Falls – see instructions at end of this chart.</p>
Sections D and F on ALT4 Screen		
75A	Assessment Result	<p>Field 75A: The outcome of the assessment activity. Choices are:</p> <ul style="list-style-type: none"> • 35 – the health risk assessment visit is completed • 39 –member refused the health risk assessment • 50 – member cannot be located for the health risk assessment • 51 – review of last HRA due to product change • 98 – used with activity type 05 to show a change in care coordinator and/or current housing
	Effective Date	<p>The effective date of the outcome identified in field 75A. The date cannot be more than 60 days after the Activity Type Date for Activity Types 01 and 02. The date must fall within a major program MA (Medical Assistance) span.</p>
	Program Type	Program type is 18

Falls Question

1. Have you experienced any falls . . . 00 ____ No 01 ____ Yes
 - a. If 1. = 01, go to 3.
 - b. If 1. = 00, go to 2.

2. If no, does concern about your balance or falling . . . 00 ____ No 02 ____ Yes
 - a. If 2. = 00, 00 is code for 3427H and in MMIS.
 - b. If 2. = 02, 02 is code for 3427H and in MMIS.
3. Fall with fracture in last 12 months? 00 ____ No 03 ____ Yes
 - a. If 3. = 00, 01 is code for 3427H and in MMIS.
 - b. If 3. = 03, 03 is code for 3427H and in MMIS.

201.05 Using Activity Types

The activity type identified in field 11 of the LTC screening document DHS-3427, indicates the type of screening or assessment. See Session 7A, Using Activity Types, in the [MMIS Training Series](#) for detailed information on the different activity types and when to use them.

Activity Type 01 - Telephone Screen

Use this activity type for nursing facility admissions. Managed care organizations complete PAS for their enrolled members. The information is entered into MMIS using form DHS-3427T.

Use this activity type to record the HRA conducted by telephone or mailed survey. Use form DHS-3428H to record the results of the HRA, and use form DHS-3427H to record the mandatory information into the MMIS.

Complete health risk assessments for persons enrolled with managed care and receiving Elderly Waiver services within 30 days of enrollment. Persons in the community must have a health risk assessment within 60 days of enrollment. Use form DHS-3428H to record the HRA and form DHS-3427H is the screening document to enter the mandatory information into MMIS.

Please see [bulletin 19-25-02](#) Preadmission Screening – Activity Required for MA-Certified Nursing Facilities for complete information

Activity Type 02 - Person to Person Assessment in the Community

This activity type represents the completion of a face-to-face assessment for a person living in the community. Use this activity type to initially open to the Elderly Waiver (EW) or Essential Community Supports (ECS) program. Use Activity Type 04 - Relocation/Transition when completing an assessment before discharged from a facility. The Referral field will need to be changed.

Health Risk Assessments by Telephone or Mailed Survey

Use activity type 02 to identify an in-person health risk assessment when the care coordinator completed the LTCC assessment or MnCHOICES assessment as the Health Risk Assessment. Complete face-to-face health risk assessments for persons enrolled with managed care and receiving Elderly Waiver services within 30 days of enrollment. Persons in the community must have a health risk assessment within 60

days of enrollment. Use the form DHS-3428H to record the HRA and form DHS-3427H is the screening document to enter the mandatory information into MMIS.

Activity Type 04 - Relocation/Transition Assessment

Activity Type 04 and Activity Type 02 operate in the same way in MMIS, with the difference being the location of the person at the time of assessment. Before a person discharges from an institution, use this activity type to indicate a face-to-face assessment

Use to open, reopen or change to the EW or ECS program upon discharge from the institution. The Referral field will need to be changed.

This activity type will also permit the MCO to document the election of ongoing Relocation Services Coordination for their members by using assessment result 18 and program type 19.

Activity Type 05 - Document Change Only

This activity type supports the need to make limited changes to an approved screening document at any time. The changes show on a new screening document rather than the initially entered document.

Some reasons to use this activity type with assessment result 98:

- 1) Changes to non-protected fields to correct errors or update information. If a field is protected (i.e., it cannot be changed using this activity) it contains information that is intended to be changed only on the basis of a face-to-face assessment (Activity Types 02 04, or 06) or eligibility update (Activity Type 09).
- 2) Updating a screening document for purposes of increasing the EW or ECS case mix cap amount after a COLA. Date the Activity Type Date and Effective Date fields after the COLA Effective Date.
- 3) Updating the Service Code Summary section.
- 4) Updating the CM/HP/CA field. This is the most frequent use of Activity Type 05.

Activity Type 06 - Reassessment

This activity type is used to code face-to-face assessments of members participating in the EW or ECS program used at least on an annual basis (within 365 days of last assessment). Schedule the annual visit at least 30 days prior to the eligibility ending date. This will allow time for the required minimum 30 day advance notice of the Denial, Termination, or Reduction (DTR) notice in case the visit results in the member no longer eligible due to not meeting level of care (exit code 21), or the minimum 10-day notice for termination for reasons other than death using exit codes 17, 20, or 23. When using exit code 22, the advance notice is required when exit reasons are not 04, 07 – 09.

Not completing a reassessment within required timelines means there will be a gap in eligibility for the person.

There are only 2 possible outcomes of a reassessment:

- The member continues on the program, or
- The member exits from the program.

Rules:

- The activity type date records the date of the screening or visit. The effective date (field 76 on the paper form) is the first of the month for reassessments.
- This activity type cannot occur before Activity Types 02 or 04 or 09.
- Using assessment result 13 will extend the eligibility period for the EW and ECS programs to the last day of the following twelfth month.
- If the visit closes the program due to loss of level of care criteria, the effective date must be at least 30 but no more than 60 days after the mailed appeal notice. Using activity type 06 and assessment result 21 will expand the eligibility end date if needed to the new exit date.
- If the visit closes the program using exit reasons 17, 20, 22 (see above exceptions for 22), or 23 the effective date must be at least 10 but no more than 60 days after the mailed appeal notice. The eligibility span end date will increase to the new exit date.
- If the person is exiting due to admission to an institution for more than 30 days which can include a continuous period of hospitalization to nursing home for more than 30 days, (or for less than 30 days of the requested relocation service coordination (RSC)), the effective date of the exit must be the date of admission.

Activity Type 07 - Administrative Activity

This activity type identifies case management activities. Use it for specific tasks and it does not replace a face-to-face assessment or case management visit. When used as an initial opening or when exiting the person from a program, see added or reduced eligibility spans on the Recipient Subsystem screens RWVR (EW) or RELG (UN with eligibility type EC).

Typically, activity type 07 use for exiting a person from a program, or to change an assessment result within 60 days of a previous face-to-face assessment or eligibility update. Activity Type 07 protects many fields. If a protected field needs changing because of new information, a face-to-face visit is required rather than using Activity Type 07. Different examples of when use this activity type are listed here.

1) Closing a program.

- *Use exit codes 17, 22 – 25 with this activity type.*
- Do not use exit reason 21 with activity type 07. Using activity type 06 determines the loss of the level of care status.
- Enter the client outcome values 02 - 11, 18, 27, 30, or 98 into field 75B.
- When a person is entering a nursing facility when leaving the HCBS program, the completion of any needed OBRA Level I screening is also documented (form DHS-3426).

- If the person is exiting due to admission to an institution for more than 30 days, including a continuous hospitalization period combined with a nursing home stay of more than 30 days, (or for less than 30 days if RSC is requested), the effective date of the exit must be the date of admission.
- If no services provided, including care coordination because the program opened by mistake or services refused before beginning, the effective date is the same day as the opening effective date. Use assessment result 25.
- Closing the program for death, the effective date is the last day providing services.

2) Recording an opening to the EW or ECS program within 60 days of a face-to-face assessment. Activity Type 07 with Assessment Result 01 is a valid combination only when immediately following Activity Type 02 or 04 or 09 with Program Type 18. The Activity Type Date of Activity Type 07 must be within 60 days of the Activity Type Date of Activity Type 02, 04, or 09.

3) Recording Relocation Service Coordination within 365 days of a face-to-face visit. See section 201.08 for more information and the MMIS training Session 10.

4) Using Assessment Result 39 identifies that the member has refused the health risk assessment. Using Assessment Result 50 identifies the member could not be found for the health risk assessment. Using Assessment Result 51 identifies the member changed products and a review of the last HRA was completed.

5) Reopening and extending a closed program due to the person appealing their program termination. See the screening document scenario for ECS, Person D.

6) Coding that the ECS person is a US citizen after pending for confirmation. Use Assessment Result 49 and change the Citizenship field to 1.

7) Use Activity Type 07 with Assessment Result 36 or 37 with the EW program to open (36) or exit (37) the Consumer Directed Community Supports (CDCS).

Activity Type 09 – Eligibility Update

Activity Type 09 allows an additional period of time when delayed eligibility determination for reasons other than the assessment. For example, an application for MA may be pending, or a delaying a planned discharge back to the community.

This activity type signifies an eligibility update by telephone rather than a face-to-face visit. While this activity type can be used up to 90 days from the date of the face-to-face assessment of activity type 02 using program type 18 with assessment results 02 or 03, or activity type 04 using program type 19 with assessment results 04 – 09, use Activity Type 07 within 60 days of the face-to-face assessment instead.

Initially open the person to EW, reopen to EW, or a change to EW. The Activity Type Date cannot be the same date as the face-to-face assessment, and not more than 90 days from the Activity Type Date of the face-to-face assessment.

Used when the initial EW eligibility determination is delayed. Do not use Activity type 09 when:

- Persons while participating in HCBS programs,
- Administrative tasks such as opening to a program within 60 days of a face-to-face visit (use activity type 07),
- A replacement for annual reassessments (use activity type 06),
- Authorizing Relocation Service Coordination after 12 months of an assessment (use activity type 04),
- Updating fields on the screening document (use activity type 05), or
- An initial assessment. Use Activity Type 02 or 04.

Use Activity Type 09 in the same ways that Activity Type 02 or 04 open, change to or return to a program. However, when completed within 90 days of a face-to-face assessment, the eligibility period for EW can begin with the effective date of the face-to-face activity type date, or up to 60 days forward from the date of the eligibility update activity type date when meeting all other eligibility criteria as of the Effective Date selected.

The end date of an EW span established using Activity Type 09 based on the activity type date of face-to-face visit. That is, the last day of the 12th month from the date of the last face-to-face visit.

Using Activity Type 09 in combination with Activity Type 07, when Activity Type 07 follows the Eligibility Update within 60 days.

- Activity Type 07 can be used to open, change or return a person to a program with an Effective Date of up to 60 days in the future from the Activity Date of Activity Type 09.
- When meeting all other eligibility criteria, use Activity Type 07 within 60 days following Activity Type 09 to retroactively open, change or return a person as early as the date of the face-to-face assessment.

Activity Type 10 –Service Change

This activity type allows changes to the screening document fields based on a face-to-face case manager/care coordinator visit when there is a need to make changes to resources and/or changes to services.

The activity type date must be August 1, 2018 or greater. The Assessment Result must be 12 – Service Change. Only use this activity type with the EW program. Use of Activity Type 10 will not extend or develop an eligibility span. Do not use when the person is receiving Moving Home Minnesota or Essential Community Supports services.

The information in the CM/HP/CA field must match the previous case manager/care coordinator/certified assessor information on the last approved screening document. When assigning a new worker, enter a screening document with Activity Type 05 and

assessment result 98 to change that field before entering an Activity Type 10 document to avoid edits.

Activity Type 10 is useful when:

- Annual reassessment is not due for a period of time, and
- The person has changed needs which will result in a need to change services, and
- The change in need and services will require additional resources (i.e. the person’s case mix classification has changed), and/or
- This change may also result in eligibility for 24 CL rate limits, or additional funding under CDCS.

Do not use Activity Type 10 when updating the person’s service plan within existing resources, or when an annual reassessment is due within 30 days. In this case, simply perform a reassessment. See [bulletin 18-25-05](#) for more information.

Entering Exit Screening Documents

Enter an exit screening document from the EW or ECS program using either Activity Type 06 or 07 when the member:

- Dies; the date of death will be the exit date;
- Enters a nursing home for more than 30 days or a combination of continuous hospitalization and nursing home exceeding 30 days. The date of admission will be the exit date;
- Moves out of the state;
- Loses Medical Assistance eligibility on a long term basis e.g. due to excess assets or income;
- Loses any other program eligibility
- Member chooses to discontinue receiving EW or ECS services;
- Is determined to have a change in condition and services no longer support the member in the community in a safe and cost effective manner.
- See the timelines in Activity Types 06 and 07 above for providing the appeal notices.

201.06 Using Assessment Results

Assessment results identify the action taken after the screening or assessment. Record values in field 75A of the LTC screening document form DHS-3427 or as the Assessment Result field on the HRA screening document and entered into the MMIS ALT4 screen. The below chart shows the correct combination of program types with assessment results.

Program Type	Assessment Result and Activity Type Description
Program Types 03 or 04 Elderly Waiver (EW)	<ul style="list-style-type: none"> • Initial Opening to Program – 01, Activity type 02, 04, or 09*

Program Type	Assessment Result and Activity Type Description
<p>LTC screening document for EW program or authorizing Moving Home Minnesota services.</p>	<ul style="list-style-type: none"> • Opening to a New Program – 10, Activity type 02, 04, or 09* • Reopening to Same Program – 11, Activity type 02, 04, or 09* • Service Change – 12, Activity type 10 • EW Reassessments – 13, Activity type 06 • Exiting the EW Program – 17, 20 – 26, Activity type 06 or 07 • Other – 98 care coordinator change, Activity type 05 <p>* Assessment results 01, 10, or 11 using activity type 09 via telephone update within 90 days of a face-to-face visit. The result is opening to the EW.</p>
<p>Program Type 30 Essential Community Supports</p>	<ul style="list-style-type: none"> • Reassessments - 13 • Exiting the program – 17, 20, 22 – 25
<p>Program Type 18 Full LTCC community screenings or health risk assessments</p>	<ul style="list-style-type: none"> • Screened/assessed and staying in the community without EW services – 02, Activity type 02 or 09* • Screened/assessed and staying in the community with no services – 03, Activity type 02 or 09* • Health risk assessment by visit – 35, Activity type 02 • Health risk assessment by telephone or mailed survey – 35, Activity type 01 • Refusal of the health risk assessment – 39, Activity type 07 • Member not found for the health risk assessment – 50, Activity type 07 • Member changes products requiring a review of the last HRA. • A change in care coordinator or a change in the current housing for HRA – 98, Activity type 05 <p>*Activity type 09 used for eligibility updates via telephone while the member is in the community.</p>
<p>Program Type 19 Screenings while in the institution</p> <p>Activity type 04: Face-to-face screening while in the NF. Values 04 – 09.</p> <p>Activity type 04: Relocation Service Coordination when last visit was more than 12 months prior. Use value 18.</p>	<ul style="list-style-type: none"> • Member resides or will reside in a NF or certified boarding care – 04 • Member resides or will reside in a non-certified boarding care - 05 • Member resides or will reside in an ICF/DD – 06 • Member was discharged from a hospital to a NF for a stay of 90 days or less – 07 • Member was discharged from a hospital to a NF for a stay of 91 days or longer – 08 • Member receives or will receive long term hospitalization – 09

Program Type	Assessment Result and Activity Type Description
<p>Activity type 07: Relocation Service Coordination when last visit was less than 12 months. Use value 18.</p> <p>Activity type 01: Use values 04, 07, and 08 with telephone screenings while in the NF. Use form DHS-3427T.</p>	<ul style="list-style-type: none"> • Member receives Relocation Service Coordination - 18
<p>Any program type</p>	<ul style="list-style-type: none"> • Value 29 (undecided) used in fields 78 – 80 • Value 98 (other) used in fields 78 – 80 unless Activity Type is 05 then value used in field 75A. • Value 99 (not applicable; no family) can be used in field 80 only

When providing **no** Elderly Waiver services (including case management) use exit 25. The eligibility span deletes and the EW “slot” immediately withdrawn.

Effective and Activity Type Date Rules

- Except for Activity Type 07 using Assessment Results 20 through 26, the Effective Date must have a date that is equal to or after the Activity Type Date.
- For eligibility updates (Active Type 09) with an Activity Type Date on or after August 1, 2013 and prior to July 1, 2017, the Activity Type Date for Activity Type 09 cannot be the same date as the face-to face nor more than 90 days from the Activity Type Date of the face-to-face visit.
- The Effective Date can be equal to the Activity Type Date of Activity Type 09 or up to 60 days in the future.
- For eligibility updates (Activity Type 09) completed on or after July 1, 2017:
- The Activity Type Date for Activity Type 09 cannot be the same date as the face-to-face nor more than 90 days from the Activity Type Date of the face-to-face visit.
- The Effective Date can be equal to the Activity Type Date of the last Activity Type 02 or 04 (face-to-face assessment) when all other eligibility criteria are met, and up to 60 days after the Activity Type Date for Activity Type 09.
- The Effective Date cannot be more than 60 days after the Activity Type Date for Activity Types 01 - 04, 06, and 09.
- The Effective Date must fall within a major program MA (Medical Assistance) span.
- The Activity Type Date cannot be prior to the last approved Activity Type Date and/or the Effective Date cannot be prior to the last approved Effective Date.
- The Effective Date using Activity Type 06 and Assessment Result 21 must not be less than 30 days and can be up to 60 days from the Activity Type Date to accommodate the need to give at least 30 days advance notice from the mailed

date of the Appeal Notice. The program eligibility span extends to match the Effective Date.

- See the advance notice rules for those exits requiring the effective date to be at least 10 and no more than 60 days from the activity type date.
- If the member on the EW program is exiting due to admission to an institution for more than 30 days this can include a combination of continuous hospitalization and nursing home admission (or for less than 30 days if member requests RSC), the effective date of the exit must be the date of admission.

Screening and Assessment Scenarios

This chart identifies a scenario in the first column and the type of screening document.

Case Type – Face to Face Screening	Actions
<p>Person A. Initial opening, reassessment, exit, and reopening</p> <p>Initial opening to the EW program.</p> <p>Person reassessed (annually or at any time).</p> <p>Person exited from program.</p> <p>Person reopens to the same program <i>within</i> 60 days of Activity Type 06; OR</p> <p>Person reopens to the same program after 60 days of Activity Type 06.</p>	<p>Activity Type 02 (from community) or 04 (from nursing facility), Assessment Result 01. The tribe enters an EW service agreement into the MMIS for those services provided by the tribe or by a provider contracted with the tribe.</p> <p>Activity Type 06, Assessment Result 13. If this is an annual reassessment, enter a tribal case managed EW service agreement. EW service agreements through SCHA do not extend beyond 12/31/18.</p> <p>See the Exit Descriptions section for each exit code and the advance notice requirements. The service agreement case managed by the tribal agency is closed.</p> <p>Activity Type 07 with Assessment Result 11. Add new service agreement if the tribe is case managing the EW services.</p> <p>Activity Type 02 or 04 with Assessment Result 11. If the tribal nation is case managing the EW or ECS services, a service agreement is entered or this new period.</p>

Case Type – Face to Face Screening	Actions
<p>Person is reassessed which results in exiting from the program.</p>	<p>Activity Type 06 with Assessment Result 17, 20 – 24 and value 02 - 11, or 98 in field 75B. See the Exit Descriptions section for each exit code and the advance notice requirements. The service agreement case managed by the tribal agency is closed.</p>
<p>Person B. Community screening, opening to program, institution, and return to community</p> <p>Person screened in the community resulting in no HCBS services.</p> <p>Person opened to EW program <i>within</i> 60 days of face-to-face assessment.</p> <p>Person will enter an institution with Relocation Service Coordination (RSC)</p> <p>Person will enter an institution for <i>more than</i> 30 days without RSC.</p> <p>Person returns to community.</p>	<p>Activity Type 02 with Assessment Results 02 or 03. Program type 18.</p> <p>Activity Type 07 with Assessment Result 01. See above service agreement instructions.</p> <p>See the Exit Descriptions for the correct Exit code. The tribal agency closes the EW service agreement.</p> <p>Activity Type 07 with Assessment Results 23 or 24 to close program. The Effective Date is the date of admission. The tribal agency closes the service agreement.</p> <p>Activity Type 07 with Assessment Result 10 with conversion program type 04 if within 60 days of last face-to-face visit. Otherwise, a new screening visit with Activity Type 02 (community visit) or 04 (institution visit) with Assessment Result 10 and program type 04. The tribal agency adds a new service agreement for those services provided by the tribe or by a provider contracted with the tribe.</p>

Case Type – Face to Face Screening	Actions
<p>Person C. Screened in the institution</p> <p>Person screened in the institution resulting in no HCBS services.</p>	<p>Activity Type 04 with Assessment Results 04 – 09 and program type 19.</p>

Case Type – Face to Face Screening	Actions
<p>Person opened to EW program <i>more than</i> 60 days from the face-to-face assessment. Add a new screening document.</p> <p>Person exited from the program. No provided services even care coordination.</p>	<p>Activity Type 02 or 04 with Assessment Result 01 and program type 04.</p> <p>Activity Type 07 with Assessment Result 25 deletes the eligibility span. EW waiver slot removed from member.</p>

Case Type – Person Opened to Disability Waiver Turns Age 65	Actions
<p>Person A. Person open to the BI or CADI program turns age 65</p> <p>Member receiving services from a disability waiver program turns age 65 and remains on program, or</p> <p>Member turns age 65 and exits program for the EW program</p>	<p>Activity Type 08 with Assessment Result 13. The lead agency has a four-month window to conduct the in-person assessment. The four-month window includes the two months before the birthday month, the birthday month, and one month after. Keep same service agreement.</p> <p>Activity Type 08 with Assessment Result 22, and value 10 in field 75B. The disability service agreement is closed. Use Activity Type 07 with assessment result 10 to open to the EW program. A tribal agency case managing the member for EW services will enter a new service agreement for those services provided by the tribe or by a provider contracted with the tribe.</p>

Case Type – Person is enrolled with Managed Care	Actions
<p>Person A: On disability waiver, person turns age 65, enrolls with MSHO or MSC+, opens to EW</p> <p>Person enrolls with MSHO or MSC+ and will change to the EW program at age 65.</p>	<p>Case manager and care coordinator work together to ensure uninterrupted services. Health plan may use the last face-to-face screening to open to EW if completed within the last 60 days. If so, the fee-for-service disability waiver service agreement is closed, and enter an exit screening document with Activity Type 07 and Assessment Result 23/10 using the last day the disability waiver.</p>

Case Type – Person is enrolled with Managed Care	Actions
	<p>If the last face-to-face visit was more than 60 days in the past or the health plan wants to complete a new visit, enter the exit screening document for the disability waiver with an Activity Type Date and Effective Date the day prior to the new visit. Close the disability waiver service agreement as of this date.</p> <p>Enter an opening screening document for the EW program with Activity Type 07 and Assessment Result 10. Enter an EW service agreement only if a tribal agency is case managing the EW services.</p>
<p>Person B – On SNBC, turns age 65, opens to EW</p> <p>Member enrolled with Special Needs Basic Care (SNBC) and turns age 65 and wishes/needs EW services. Member will disenroll from SNBC and case manager opens Elderly Waiver fee-for-service for the month following disenrollment.</p> <p>Member chooses MSC+ or MSHO.</p>	<p>Activity Type 02 or 04, Assessment Result 01, 10, or 11 to open to EW. If the Activity Type Date is prior to age 65, the Effective Date must be the 65th birthdate or later. Enter fee-for-service service agreement for the period before MSC+ or MSHO begins.</p> <p>Do not add an exit screening document. Add a screening document to change the case manager with Activity Type 05 and Assessment Result 98. Close the fee-for-service EW service agreement unless a tribal agency is providing the EW case management for those services provided by the tribe or by a provider contracted with the tribe.</p>
<p>Person C – Disenrollment from MCO due to COR change or other reasons</p> <p>Member changes county of residence and current health plan does not provide services in new county of residence, or member loses managed care eligibility for any other reason. Member will continue on the EW program but disenrolls from MSHO or MSC+.</p>	<p>The health plan care coordinator:</p> <ol style="list-style-type: none"> 1. Does not enter an exit screening document. 2. Contacts the county/tribal case manager to discuss the care plan and to assure there is no disruption in services. <p>The county or tribal case manager will:</p>

Case Type – Person is enrolled with Managed Care	Actions
	<ol style="list-style-type: none"> 1. Arrange for services. 2. Complete a face-to-face visit if the annual review is due or if it is determined that a reassessment visit is necessary. 3. Enter the results of the visit with the updated information using Activity Type 06 and Assessment Result 13. 4. Enter a fee-for-service service agreement starting with the day after the MSHO or MSC+ enrollment period ends. 5. If no reassessment visit is due or necessary, enter an Activity Type 05 with Assessment Result 98 document to change the LTCC County field to the new agency and change to the new case manager number.
<p>Person D – Person using EW services enrolls with MSHO or MSC+ while case managed by county agency</p> <p>Member enrolls with MSHO or MSC+ while on fee-for-service Elderly Waiver with county lead agency.</p>	<p>County staff managing the care plan must take the following actions when it has been determined that the member receiving Elderly Waiver services is enrolled with the MSHO or MSC+ program:</p> <ol style="list-style-type: none"> 1. Do not enter an exit screening document. 2. The service agreement will be closed to the day prior to the enrollment begin date. 3. Consult with the health plan care coordinator to discuss the member’s care plan so there is no disruption in service delivery and notify them of the date of the next annual review. <p>The health plan coordinator will then:</p> <ol style="list-style-type: none"> 1. Arrange for services. 2. Enter a screening document using Activity Type 05 and Assessment Result 98 to change the LTCC field to the health plan code and the CM/HP/CA UMPI number

Case Type – Person is enrolled with Managed Care	Actions
	<p>field to the care coordinator’s provider number.</p> <p>3. Complete a face-to-face visit if the annual review is due or if it is determined that a reassessment visit is necessary.</p> <p>4. Enter the results of the visit with the updated information using Activity Type 06 and Assessment Result 13.</p>
<p>Person E – EW person enrolls with MSHO or MSC+ while case managed by tribal agency</p> <p>Person enrolls with MSHO or MSC+ while on fee-for-service Elderly Waiver with tribal agency.</p>	<p>If the tribe will continue to case manage the person, both agencies will coordinate services. Do not enter an exit screening document. The service agreement is not closed. The service agreement authorizes those services not paid by the health plan.</p>

Case type: Consumer Directed Community Services (CDCS)	Action
<p>The member requests the CDCS service option upon opening to the EW program.</p>	<p>Activity Type 02 with Assessment Result 01, 10, or 11 and Program Type 03 or 04. CDCS Field = Y and “CDCS” (code 40) is marked in the Service Plan Summary along with “Paid CDCS Parent/Spouse” (code 41) if applicable.</p> <p>A member case managed by a tribal agency will add an EW CDCS service agreement.</p>
<p>The member elects CDCS services while already opened to the Elderly Waiver benefit set.</p>	<p>Activity Type 07 with Assessment Result 36. CDCS Field = Y and “CDCS” is marked in the Service Plan Summary along with “Paid CDCS Parent/Spouse” if applicable.</p> <p>A member case managed by a tribal agency will close the EW service agreement and add an EW CDCS service agreement.</p>

Case Type – Health Risk Assessments (HRA)	Actions
<p>A telephone screening</p> <p>A mailed survey</p>	<p>Complete form DHS-3428H by telephone. Enter the information onto form DHS-3427H to enter into the MMIS. Use Activity Type 01 and Assessment Result 35. Use Program Type 18.</p> <p>Send form DHS-3428H with the following fields completed by the care coordinator:</p> <ul style="list-style-type: none"> • Name • Recipient ID/PMI # • Health Plan Reference Number (if any) • Type of Activity (use 01) • Counties • Care Coordinator UMPI Number • Assessment Team • Assessment Result • Program Type <p>For screenings conducted on or after September 1, 2017, enter the document into MMIS under document type H on the Key Panel Screen even if the member is currently on a HCBS program.</p> <p>For screenings conducted prior to September 1, 2017, do not enter the document if the date overlaps with the waiver period. See Section 201.07 for the mandatory fields.</p>
<p>Person B – Person refuses the health risk assessment</p>	<p>Complete form DHS-3427H. Use Activity Type 07 with Assessment Result 39 and Program Type 18 when the member refuses the health risk assessment.</p> <p>For screenings conducted on or after September 1, 2017, enter the document under document type H even if the member is currently on a HCBS program.</p> <p>For screenings conducted prior to September 1, 2017, do not enter the document if the date overlaps with the</p>

Case Type – Health Risk Assessments (HRA)	Actions
	waiver period. See Section 201.07 for the mandatory fields.
Person C – Person cannot be found for the health risk assessment	<p>Complete form DHS-3427H. Use Activity Type 07 with Assessment Result 50 and Program Type 18 when the member cannot be located for the health risk assessment.</p> <p>For screenings conducted on or after September 1, 2017, enter the document under document type H on the Key Panel Screen even if the member is currently on a HCBS program.</p> <p>For screenings conducted prior to September 1, 2017, do not enter if the date overlaps with the waiver period. See Section 201.07 for the mandatory fields.</p>
Person D – There is a change in the care coordinator	Complete form DHS-3427H. Use Activity Type 05 and Assessment Result 98. Change the CM/HP/CA field on the ALT1 screen as well as the LTCC County field. See Section 201.07 for the mandatory fields.
Person E – Member changes products	The care coordinator will enter a screening document with activity type 07 and assessment result 51 to complete a review of the last health risk assessment. The Effective Date field must match the Effective Date of the last Assessment Result 35 and not be more than 366 days from the current date.

201.07 Mandatory Fields for Document Type L

Which fields are mandatory for completion is dependent on the program type and in many cases which activity type or assessment result is used.

Program Type 18 for the Full LTCC Using Assessment Results 02 or 03 (Community Screenings)

The following fields are mandatory.

Section A/ALT1 Screen

- Date of Birth
- Referral Date
- Activity Type
- Activity Type Date
- County fields
- Primary Diagnosis
- DD, MI, BI Diagnosis History fields
- CM/HP/CM Number

Section B/ALT2 Screen

- Present at Screening
- Reasons for Referral
- Team
- OBRA Level 1 Screening
- Current Housing
- ~~Current and Planned Program License~~
- OBRA Level 2 Referral: MI DX and DD DX

Section C/ALT3 Screen

These fields are **not** mandatory:

- Clinical Monitor
- Disability Cert
- Hearing
- Communication
- Vision
- Vent Dep

Section D/ALT4 Screen:

- Assessment Result
- Effective Date
- Informed Choice
- Level of Care

All of Section E is to be completed.

- PCA Complex field identifies if the member assessment found eligibility for 12 or more hours of PCA. It is mandatory for Effective Date 7/1/18 and greater. For case mix A – H and L, the field will auto populate with an “N”. For case mix V,

the field will auto populate with a Y. For case mix I, J, and K, the worker must add an N or Y to resolve edit 163.

Section F/ALT4 Screen

- Program Type

Section G/ALT5 Screen

- At least one value is needed for Section G

Program Types 03 or 04 (EW)

The following fields are mandatory to open, reopen, and/or complete the reassessment.

Section A/ALT1 Screen

- Date of Birth
- Referral Date (mandatory for Activity Types 02 and 04)
- Activity Type
- Activity Type Date
- County fields
- Legal Rep Status
- Primary Diagnosis
- DD, MI, BI Diagnosis History fields
- CM/HP/CM Number

Section B/ALT2 Screen

- Present at Screening
- Informal Caregiver
- Marital Status
- Reasons for Referral
- Current and planned Living Arrangement
- Team
- OBRA Level 1 Screening
- Current and Planned Housing
- ~~Current and Planned Program License~~
- OBRA Level 2 Referral: MI DX and DD DX

Complete all of Section C/ALT3 Screen

Section D/ALT4 Screen

- Assessment Result
- Exit Reasons (only when exiting from the program)
- Effective Date
- Informed Choice
- Client Choice
- Family Choice
- LTCCC/IDT Recommendation

- Level of Care

Complete all of Section E/ALT4 Screen

- PCA Complex field identifies if the member assessment found eligibility for 12 or more hours of PCA. It is mandatory for Effective Date 7/1/18 and greater and for EW. For case mix A – H and L, the field will auto populate with an “N”. For case mix V, the field will auto populate with a Y. For case mix I, J, and K, the worker must add an N or Y to resolve edit 163.
- Services field is mandatory for activity type 06 and PAS County field = MCO value for all reassessments on and after 8/1/2018. If value is AD, CL, or FC then Provider NPI and Person fields are mandatory. See form DHS-3428Q for answers.

Complete all of Section F/ALT4 Screen

Section G/ALT5 Screen

- Service Plan Summary. Enter at least one value for Section G and at least one of the values must be an EW service with indicator F. If using the extended PCA code then also indicate MA PCA. If authorizing EW customized living services, there must be values with code C listed here.
- Person’s Evaluation of Foster Care, Customized Living, and Adult Day Services. If Person field is 1 or 2 then these fields are mandatory. Use form DHS-3428Q for answers to these questions. If the Services field = FC or CL, the all fields except ADL are mandatory. If Services field = AD, then only RSPT through ADL fields are mandatory.

Program Type 19 – Nursing Home Screenings Using Assessment Results 04 - 09

The following fields are mandatory.

Section A/ALT1 Screen

- Date of Birth
- Activity Type
- Activity Type Date
- County fields
- Primary Diagnosis
- DD, MI, BI Diagnosis History fields
- CM/HP/CM Number

Section B/ALT2 Screen

- Present at Screening
- Reasons for Referral
- Team
- OBRA Level 1 Screening
- Current and Planned Housing
- ~~Current and Planned Program License~~
- OBRA Level 2 Referral: MI DX and DD DX

Section C/ALT3 Screen

- A value higher than 00 in the NF Stays field is required

Section D/ALT4 Screen

- Assessment Result
- Effective Date
- Informed Choice
- Level of Care
- Reasons for Cont. NF Stays or CDCS Ending

All of Section E is to be completed

Section F/ALT4 Screen

- Program Type

Section G/ALT5 Screen

- No fields are to be completed

Coding Examples for Section B: Living Arrangement, Housing Type, and Program License

The Current and Planned Program License fields are not mandatory as of July 2020. We will delete the fields from the MMIS ALT2 screen soon.

Scenario	Field Coding
Member residing in and will continue to live in foster care	<ul style="list-style-type: none"> • Current Living Arrangement = 04 • Planned Living Arrangement = 04 or 06 • Current/Planned Housing Type = 05 • Current/Planned Program License = 05 or 06
Member lives alone and will continue to live alone in an apartment or other home. Living alone means no one else lives with the person.	<ul style="list-style-type: none"> • Current/Planned Living Arrangement = 01 • Current/Planned Housing Type = 09 • Current/Planned Program License = 09
Member lives in an apartment provided with customized living services. An apartment is a self-contained unit that includes <i>private</i> space for sleeping, cooking, dining, living, and a bathroom. They have a roommate.	<ul style="list-style-type: none"> • Current/Planned Living Arrangement = 03 • Current/Planned Housing Type = 09 • Current/Planned Program License = 07
Member lives in building, licensed for customized living services, with several others. Each person has a bedroom with an attached bath. All other space for living, dining, cooking is shared accommodation.	<ul style="list-style-type: none"> • Current Living Arrangement = 04 • Planned Living Arrangement = 04 or 06 • Current/Planned Housing Type = 04 • Current/Planned Program License = 07
Member lives in a nursing facility and will return to the community to an apartment with spouse and use customized living service.	<ul style="list-style-type: none"> • Current Living Arrangement = 04 • Planned Living Arrangement = 02 • Current Housing Type = 11 • Planned Housing Type = 09 • Current Program License = 11 • Planned program License = 07

[201.08 Mandatory Fields for Document Type H](#)

Protected fields are not mandatory. Below are the fields that are mandatory when using assessment result 35 and the Activity Type Date is 08/01/2018 or greater.

Completed Health Risk Assessment Using Assessment Result 35

Section A/ALT1 Screen

- Reference Number (may be left blank if there isn't an alternative MCO number)
- Date of Birth
- Referral Date

- Activity Type
- Activity Type Date
- COS, COR, and CFR (must be completed but fields will change to values located on the Recipient Subsystem)
- LTCC County
- Care Coordinator UMPI Number

Section B/ALT2 Screen

- Assessment Team
- Dental Concerns
- Do you have a dentist?

Section C/ALT3 Screen

- ADL Fields (dressing, grooming, bathing, eating, bed mobility, transferring, walking, toileting, and self-evaluation)
- Hearing
- Vision
- Communication
- IADL Fields for Activity Type 02 (phone calling, shopping, preparing meals, light housekeeping, medication management, money management, and transportation)
- Falls, Hospitalizations, ER Visits, and NF Stays

Sections D and F/ALT4 Screen

- Assessment Result
- Effective Date
- Program Type

Below are the fields that are mandatory when using assessment results 39, 50, or 98.

Incomplete Health Risk Assessment – Person Refuses HRA or is Not Located Care Coordinator Change

Section A/ALT1 Screen

- Date of Birth
- Activity Type
- Activity Date
- County Fields
- CM/HP/CA Number

Section B/ALT2 Screen

- No fields are to be completed

Section C/ALT3 Screen

- No fields are to be completed

Section D/ALT4 Screen

- Assessment Result
- Effective Date

Section E/ALT4 Screen

- No fields are to be completed

Section F/ALT4 Screen

- Program Type

[Review of the Last Health Risk Assessment – Assessment Result 51](#)

Section A/ALT1 Screen

- Date of Birth
- Activity Type
- Activity Date
- County fields
- CM/HP/CA Number

Section B/ALT2 Screen

- No fields are to be completed

Section C/ALT3 Screen

- All fields but Family Planning Needs and Sexually Active

Section D/ALT4 Screen

- Assessment Result
- Effective Date

Section F/ALT4 Screen

- Program Type

[201.09 Disenrollment from Managed Care](#)

Upon notification that the member using Elderly Waiver services will dis-enroll from MSHO or MSC+ (either by notification from the member or from the monthly disenrollment reports), the care coordinator must contact the preadmission screening unit of the county of service so EW services will continue through fee-for-service. Do not enter an exit screening document in this case.

It is possible that the disenrollment was due to a change in health plans. A member may not enroll in more than one health plan at the same time. Enrollment in a new health plan automatically dis-enrolls the member from the previous health plan.

In some cases, there will be a lapse of one month in between enrollment spans of the old and the new health plan. In order to assure that providers reimbursed for services during this period, it is necessary that there is service coordination among all parties. In this case, the county of service enters a fee-for-service service agreement for the period of no enrollment for any EW services that are continuing. The current care coordinator provides information about services, units, and providers to the case manager.

When enrollment starts with the new health plan, the new care coordinator may complete a face-to-face visit immediately or wait until the next scheduled annual visit. If the health plan is South Country Health Alliance and EW services provided, enter a service agreement starting with the new enrollment period if the enrollment begins in 2018. Only tribal agencies case managing EW services for members, will authorize and receive payment from the MMIS after January 1, 2019.

201.10 Nursing Facility Admissions Less than 30 Days

A member on the waiver program who enters a nursing facility but anticipates that they will return to the community with EW services within 30 days, **and** will not use Relocation Service Coordination (RSC), does not need to be exited from the program.

If the member does not return to the community within thirty days, an exit screening document is entered with an effective date the same as the admission date.

201.11 Authorizing Moving Home Minnesota (MHM) Services

MHM transitional services provides up to 180 days to qualified persons living in specific institutions. These services consist of the plan development (T2038 U6) and coordination. (T2038 U6 UD). See the [Moving Home Minnesota Program manual](#) for information on qualified persons, institutions, and community residences. Do not enter the transitional services on the service agreement; the health plan pays for these services.

The LTC screening document contains a field called MHM field in Section F of form DHS-3427 and on the ALT4 screen. Placing a “Y” in this field, billing for the community under the MHM billing codes. Complete these fields on the LTC screening document to authorize MHM community services. Enter a LTC screening document even if the member enrolls with MSHO or MSC+.

Field Name	Value
Field 11 – Activity Type	Value 04
Field 27 – Current Living Arrangement	Value 04

Field Name	Value
Field 33 – Current Housing Type	Value 02, 03, or 11
Field 34 – Planned Housing Type	Value 05 or 09
Field 75A – Assessment Result	Value 04, 06 – 09, or 18
Field 104 – Program Type	Value 19
Field 105 – MHM IND	Value Y
<p>Service Plan Summary</p> <p>Once the person is open to the waiver, or if under age 65 and in the community with no waiver services and only MHM services, the service plan summary may include any of these community services.</p> <p>Add services to the waiver service agreement.</p>	<p>For transitional services, use value NF - 34 or Other - 98 with “F” funding source.</p> <p>The following community services may have a source code of “M”:</p> <ul style="list-style-type: none"> ▪ 17 – Overnight supervision ▪ 21 – respite in home ▪ 24 – mental health services ▪ 26 – home modifications ▪ 27 – caregiver training ▪ 45 – extended supplies/equipment ▪ 48 – supported employment ▪ 52 – PERS ▪ 91 – case consultant ▪ 92 – self-advocacy training ▪ 93 – comprehensive community support services ▪ 94 – youth assertive community treatment ▪ 95 – certified peer specialist ▪ 96 – membership fees ▪ 97 – transport to acquire housing/employment ▪ 99 – employment equipment

[201.12 Essential Community Supports \(ECS\) Program](#)

Members who lost their level of care while on a waiver program as of January 1, 2015 were able to transition from these waiver programs to the ECS program through December 31, 2015. They will remain on ECS if they continue to meet the program’s eligibility criteria. Members screened after this date may not open to ECS. Members who are eligible for PCA services are not eligible for ECS services. These are individuals who are eligible for Medical Assistance and their ADL scores on the screening document show that bathing, or dressing, or grooming, or walking is greater than 01 or eating is greater than 02.

[ECS Screening Document Mandatory Fields](#)

The following fields are mandatory to open, reopen, and/or complete the reassessment.
Section A/ALT1 Screen

- Date of Birth

- Activity Type
- Activity Type Date
- County fields
- Legal Rep Status
- Primary Diagnosis
- DD, MI, BI Diagnosis History fields
- CM/HP/CM Number

Section B/ALT2 Screen

- Present at Screening
- Informal Caregiver
- Reasons for Referral
- Marital Status
- Current and Planned Living Arrangement
- Team
- Current and Planned Housing
- ~~Current and Planned Program License~~

Complete all of Section C/ALT3 Screen

Section D/ALT4 Screen

- Assessment Result
- Exit Reasons (only when exiting from the program)
- Effective Date
- Informed Choice
- Client Choice
- Family Choice
- LTCCC/IDT Recommendation
- Level of Care

Complete all of Section E/ALT4 Screen

Complete all of Section F/ALT4 Screen

Section G/ALT5 Screen

Enter at least one value for Section G

ECS Services

- Chore S5120
- Homemaker S5130
- Homemaker with home management S5130 TF
- Homemaker with ADL assistance S5130 TG
- Personal Emergency Response System S5160 (install), S5161 (monthly fee), or S5162 (purchase)

- Family Caregiver Training and Education S5115
- Family Caregiver Coaching and Counseling S5115 TF
- Home Delivered Meals S5170
- Community Living Assistance in person and remote H2015*
- Community Living Assistance remote H2016*
- Adult Day Services 15 minutes S5100
- Adult Day Services FADS 15 minutes S5100 U7

* Authorize and bill Community Living Assistance H2015 may be by itself. Authorize H2016 at least one day during the same time as H2015 (face to face) and both services approved with the same provider.

Tribal staff will enter the ECS service agreement for their fee-for-service individuals, and any individual enrolled with any health plan with SNBC, MSHO, or MSC+ that they care coordinate or case manage. The SACTAD field is completed.

For members not case managed by a tribal agency and enrolled with MSHO or MSC+ with any health plan, the health plan will also complete and submit an ECS service agreement. The health plan billing system does not pay for ECS services.

[ECS Workbook Discontinued and Replaced by Form DHS-3070](#)

Use of the ECS workbook discontinued as of June 30, 2019. Effective July 1, 2019, MCO staff that previously used the ECS workbook must use form [DHS-3070](#) Service Agreement. Because MCO staff will not have security to data enter this new service agreement type into the MMIS, use your contracted lead agency staff who currently have MMIS access to enter a service agreement directly into the MMIS; or submit form DHS-3070 using the process explained on the [CBSM-ECS](#) page.

[201.13 Consumer Directed Community Supports \(CDCS\)](#)

This section gives instructions for coding the CDCS for members using Elderly Waiver services. Members receiving Essential Community Support services are not eligible for CDCS services. Session 10 of the [MMIS Training Series](#) also covers CDCS information.

Consumer-directed Community Supports (CDCS) is a service that gives individuals more flexibility and responsibility for directing their services and supports, including hiring and managing direct care staff. CDCS may include traditional goods and services, as well as additional allowable services that provide needed support to persons. CDCS services not allowed to members during a current Primary Care Utilization Review period. In MMIS, the PCUR screen shows this restriction and edit 442 “Services Not Allowed Due to MRRP” will post if the CDCS field equals Y. On Section G, two values record CDCS on the Service Summary Screen. They are 40 (CDCS) and 41 (Paid CDCS Parent/Spouse).

The form [DHS-6633A](#) is the Community Support Plan Addendum. The EW and AC budget increase effective July 1, 2020 updates this form.

For EW program, the monthly CDCS budget cap amount uses the data entered in the Effective Date, Case Mix Level, and Program Type fields on the MMIS screens and is automatically populated. Exceeding the dollar amount for EW conversions when DHS staff approve the higher nursing home rate. *Edit 672 “Total Authorized Amount Exceeded” will no longer post, if the total authorized amounts of the above line items exceed the CDCS EW upon exiting.*

The EW program uses two CDCS assessment result values. The purpose of these assessment result values is to identify funding changes.

Assessment Result 36 called “Elected Elderly CDCS” used when the member is switching to CDCS from non-CDCS services. Edit 448 “CDCS Field Equals N” will post if the CDCS field is not a Y.

- Assessment Result 37 “Elected Elderly Non-CDCS Services from CDCS” used whenever the person switches to non-CDCS services from CDCS. When this assessment result is used the field Nursing Home Continued Stay/CDCS Ending on the MMIS ALT4 screen, is required to record up to two reasons why the member chose to end CDCS. Edit 449 “CDCS Field Equals Y” will post if the CDCS field is not an N.
- These assessment results will not change the eligibility span.
- They are not exits.
- It identifies the period using CDCS.

CDCS Services

There are three procedure codes to identify CDCS services.

- T2028 to authorize all CDCS services. It includes the following service categories: Personal Allowance; Medical Treatment and Training, Environmental Modifications and Provisions, and Self-Direction Support Activities. Modifiers on the claim form identify the service category.
- T2040 to authorize payment for Background Checks.
- T2041 includes all activities for Required Case Management for the EW program.

201.14 Relocation Service Coordination (RSC)

RSC recorded in MMIS using activity type 04 and program type 19 when the last visit was more than 12 months before admission. Activity type 07 and program type 19 is used when the last visit was within 12 months before admission. In both cases, assessment result 18 is used. Enter an exit document for EW as of the date of admission if EW is open when the person enters a nursing facility and requests RSC.

201.15 The Role of the Screening Document in Rate Cell Assignment

MSHO Product

The monthly payment rate to the health plan for each member is determined by the rate cell assigned to the member. Each rate cell has a different payment rate. This

assignment is determined for the next month six days prior to the end of the current month. There are three rate cells.

- Rate Cell A assigned for members with a living arrangement in the community with no open EW waiver span.
- Rate Cell B assigned for members with a living arrangement in the community with an open EW waiver span.
- Rate Cell C assigned for members aged 65 and older who is eligible for Moving Home Minnesota services while open to the Elderly Waiver program.
- Rate Cell D assigned for members with a living arrangement of institutional and no open EW waiver span.

For rate cell B, the EW eligibility span includes the following month for the capitation run in the current month. If the eligibility span ended the last day of the current month and the document entered prior to the current month's capitation date, the rate cell will change to A for the following month. To avoid changing the rate cell from B to A, enter the annual reassessment visit that is due in the twelfth month of the eligibility span into MMIS prior to the capitation date of that month. See the [managed care key dates](#) document for the capitation dates. Rate cells do not retroactively corrected. However, EW services must continue in order to meet the person's needs regardless of the rate cell.

It is possible that a member with rate cell A or D becomes eligible for EW services. EW services must begin on or after the date the person is found eligible for payment of LTC services regardless if the rate cell is A or D for the first month.

[MSC+ Product](#)

The same capitation process used to determine if the person enrolled with MSC+ with have product ID MA30 or MA35. Product IDs determine the monthly payment rate. MA35 signifies an open waiver span is present in MMIS on the day of capitation. MA30 indicates no open waiver span is present in MMIS on the day of capitation. The screening document plays the same role. If the EW eligibility span is not open on the day of capitation, the product ID will change from MA35 to MA30. Persons eligible for Moving Home Minnesota services while open to the Elderly Waiver program will have a product ID of MA36.

[201.16 Members Opened to BI, CAC, CADI, or DD Programs](#)

Members age 65 and older who continue on these programs and enrolled with managed care may remain on these waiver programs under MSHO or MSC+. The county or tribal case manager will continue to manage the waiver services. Do not enter a MSHO or MSC+ screening document for persons on these waiver programs as document type L, but a health risk assessment should be entered as a document type H as described in section 201.03. Persons receiving Moving Home Minnesota services will have a fee-for-service service agreement entered for those services.

Use the Managed Care Organization/County/Tribal Agency Communication form [DHS-5841](#) to facilitate communication about home care services between the disability waiver case manager and the MCO staff.

201.17 Reassessments and Eligibility Spans

Assess members opened to the EW or ECS program at least once every 365 days based on the Activity Type Date field. The care coordinator must arrange a face-to-face visit within this period. Record the actual face-to-face date in the Activity Type Date field. The Effective Date field can be the same date as the Activity Type Date or it can be a future date up to 60 days. The date in the Effective Date field:

- Sets the begin date of the eligibility span on the RWVR screen (waiver or ECS) or RELG screen (ECS) when using assessment results 01, 10, or 11.
- Increases the eligibility span using assessment result 13.
- Decreases the span for exits using assessment results 17, 19 – 24. Assessment Result 25 removes the EW eligibility span.

Waiver and Essential Community Supports Eligibility Spans

The effective date of the initial opening or reopening screening document is any day within the month. An eligibility span of 12 months develops with the end date being the last day of the twelve month.

For reassessments, the activity type 06 is the first day of the month that follows the end of the eligibility period on the RWVR screen. An example is the program opens with an effective date of February 2019 will have an eligibility span that ends the last day of January 2020. The activity type 06 document then has an **effective date** of 2/1/19 to extend the eligibility period to 1/31/20. ECS reassessment documents also extends the major program UN with eligibility EC span on RELG.

Exiting EW Program and Appeal Notice Requirements

When the member leaves the program, the exit document will have an effective date at least ten days and not more than 60 days in the future from the date the appeal notice was mailed in order to comply with the advance notice requirement. This timeframe is required when the exit code is 17 using activity type 06, or exit codes 20, 22 (see exceptions), or 23. Using code 21 for members who no longer have nursing home as their level of care must be at least 30 and up to 60 days after the mailed appeal notice. The EW eligibility span end date increases to match the effective date, if necessary.

No Matching Waiver Segment Message

If a reassessment or exit screening document entered for a program type that is not the same as the opening screening document, the message “PMMW9687 S625-020 NO MATCHING WAIVER SEGMENT” will appear on the screen after using the PF3 key. Correct the program type.

If the reassessment visit did not occur within the eligibility period, enter an exit screening document with an effective date that matches the last day of the current eligibility period and a reopening document with the activity and effective date of the reassessment visit is entered to begin a new eligibility period.

The message will also appear if the exit effective date is not within the waiver eligibility span for exit codes that do not need advance notice (codes 17 using activity type 07, 24, or 25 and in some cases, 22). In order to satisfy this requirement, the effective date may need to be beyond the current eligibility end date.

[201.18 Using the MMIS Prior Authorization Subsystem](#)

The [MMIS Training series](#) are online trainings found on TrainLink. Sessions provide instruction on how to use the MMIS in general as well as for both screening documents and service agreements. Session 1 is mandatory. If you are new to using the MMIS, we recommend completing sessions 2 through 4 and then any other session you need.

- Session 1 – Introduction to MMIS
- Session 2 – MMIS Security Log in and Passwords
- Session 3 – Basic Navigation in MMIS
- Session 4 – Using Programming Function (PF) Keys
- Session 5 – The Recipient Subsystem
- Session 6 – Introduction to the LTC Screening Document
- Session 7 – Viewing the LTC and HRA Screening Document
- Session 7a – Understanding Activity Types and their Timelines
- Sessions 8, 8a – Data Entering the LTC Screening Document
- Session 8b – Data Entering the Health Risk Assessment (HRA) Document into MMIS
- Session 9 – The LTC screening document for the MSHO and MSC+ Programs
- Session 10 – Coding the LTC Screening Document for Other Services
- Session 11 – DHS Approval of the LTC Screening Document
- Session 12 – Locating Suspended Documents for Correction or Deletion
- Session 13 – Deleting the LTC and HRA Screening Document

Other sessions focuses on the service agreement.

- Session 14 – Introduction to the Service Agreement
- Session 15 – Service Agreement Inquiry
- Session 16 – Entering New Service Agreements into MMIS
- Session 16a – Service Agreements and Provider Edits
- Session 17 – Service Agreement Changes
- Session 18 – Alternative Care Fees
- Session 19 – The Elderly Waiver Customized Living Services Process
- Session 20 – Service Agreements for Managed Care Members
- Session 21 – Methods to Location Suspended and Partially Suspended Service Agreements

201.19 DHS Approval of the Screening Document

Session 11 in the [MMIS Training Series](#) explains the processes for approving:

- The nursing home rate for Elderly Waiver conversions
- Moving Home Minnesota screening documents

201.20 Ineligible Period for Waiver, ECS, and AC Services

Members found to be ineligible due to an improper transfer of assets are not eligible for waiver, ECS, or nursing home services during the penalty period. See this policy in the Health Care Programs manual, section 0909.27.11. The county financial worker determines the ineligible period and records it on the RLVA screen of MMIS.

The Eligibility Verification System (EVS) includes a message for providers that says “this person is ineligible for AC, ECS, waiver, and long term care services” when the dates of service for these programs overlap with the penalty period.

LTC screening document edit 937 “Ineligible Asset Transfer” will post for the opening, reopening, and reassessment screening documents in which the Effective Date field overlaps with a penalty period of “A, F, H, I, L, N, or U”. If you receive this edit, contact the county financial worker to review the RLVA screen on the Recipient Subsystem for the penalty period. Note: the ECS eligibility span overlapping with a U ineligible span will not post edits. For waiver persons, contact the financial worker to delete the U span if it is determined there is no penalty period. The U span automatically added to the RLVA screen for added MA related programs.

Ineligible Codes

A = Annuity penalty

F = Pending receipt of DHS-3543 (no longer valid)

H = Home equity exceeds limit

I = Uncompensated transfer

L = Level of care criteria is not met

N = Enrollee not cooperate to determine level of care criteria

U = Undetermined

Opening or Continuing on Program

Not allowed: A program opening or reopening screening document (activity type 02 or 04 and assessment result 01, 10, or 11) effective date falling within the ineligibility period. Change the effective date so it is greater than the ineligibility end date.

Not allowed: A reassessment document (activity type 06 and assessment result 13) with the effective date field falling within the ineligibility period. Add an exit screening document dated the day prior to the penalty period. A reopening screening document is then entered for the day after the penalty periods ends.

Edit 938 “Eligibility Overlap with Ineligibility Period” will post if the assessment result is opening, reopening, or reassessment and the effective date field is prior to the ineligibility period but the end date of the waiver span or ECS eligibility span overlaps with an ineligible period. By forcing this edit, it allows the screening document to be approved but the eligibility span will be shortened to one day prior to the begin date of the ineligibility span on RLVA. To continue services after the ineligibility period ends, enter an exit screening document with an effective date of the day prior to the ineligibility begin date. Enter a reopening screening document dated one day after the ineligibility period ends.

Session 4 of the [MMIS Training Series](#) describes these MMIS Recipient Subsystem screens showing the ineligibility spans (RLVA), the waiver eligibility span (RWVR), and the ECS eligibility span (RELG).

Chapter 3

301.01 Resources

Publications, Forms, and Resources Webpage

The [Publications, forms, and resources webpage](#) gives access to the following:

- DHS manuals including:
 - Community-Based Services Manual (CBSM)
 - How to Enter the Health Risk Assessment into MMIS for the SNBC Program
 - How to Enter the Long Term Care Screening Document and Service Agreement into MMIS
- Guidelines to the Investigation of Vulnerable Adult Maltreatment
- Bulletins from the last three years
- eDocs for DHS forms and brochures

View, copy, and download these forms from eDocs.

Form Number	Form Name
DHS-2497	Long Term Care Consultation Brochure
DHS-3361	Nursing Facility Level of Care Brochure (people under age 21)
DHS-3428B	AC, BI, CADI, EW Case Mix Classification Worksheet
DHS-3428C	MN Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children Under 18
DHS-3426	Level 1: Screening for Mental Illness or Developmental Disability
DHS-3427	LTC Screening Document: AC, BI, CAC, CADI, ECS, EW, MHM, MSC+, MSHO
<i>DHS-3427H</i>	Health Risk Assessment Screening Document
DHS-3427T	LTC Screening Document: Telephone Screening
DHS-3428 and DHS-3428A	MN LTC Consultation Services Assessment Forms
<i>DHS-3428D</i>	Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan
<i>DHS-3428H</i>	Minnesota Health Risk Assessment
DHS-3214A	Notice about Your Rights and Responsibilities for the Minnesota Senior Health Options
DHS-4166	Electronic (updateable) Community Support Plan
DHS-7028	Nursing Facility Level of Care Criteria: Determining Service Eligibility for Medical Assistance Payment of Nursing Facility Services and Home and Community-Based programs
DHS-2828A and B	Long-Term Services and Supports Notice of Action

Adults

The [Adult webpage](#) includes the following:

- Adult protection

- Deaf and hard of hearing
- Seniors
- People with disabilities

Email Subscriptions to Listservs

DHS provides [subscriptions](#) to public email lists. This page shows the Aging and Adult Services Lead Agency listserv which provides information about the Elderly Waiver, Alternative Care, LTCC programs as well as new bulletins, policy information, and MMIS changes. Obtain archive memos here also.

You can also register for the Aging and Adult Services Video Conferencing listserv to receive announcements of new video conference training sponsored by the Aging and Adult Services division.

Aging and Adult Services Division Trainings

The division is suspending trainings by video conferences for the remainder of 2020. In addition, online modules accessible through TrainLink provide instruction on using the MMIS for the LTC screening document, Health Risk Assessment screening document, and service agreements. The [Aging Training](#) page provides more information to access these trainings.

301.02 DHS Health Plan Enrollment, Education, and Outreach Coordinators

Kay Moe-Duffy (651) 431-2770 Back-up: Carla	Carolyn Braun (651) 431-2483 Back-up: Karen	Viseth Sin (651) 431-2486 Back-up: Jean	Joan Anderson (651) 431-3268 Back-up: Chris
Brown (08)	Anoka (02)	Blue Earth (07)	Beltrami (04)
Dodge (20)	Carver (10)	Cook (16)	Big Stone (06)
Freeborn (24)	Chippewa (12)	Houston (28)	Clearwater (15)
Goodhue (25)	Dakota (19)	Itasca (31)	Douglas (21)
Kanabec (33)	Kandiyohi (34)	Koochiching (36)	Grant (026)
Morrison (49)	Lac Qui Parle (37)	Lake (38)	Hubbard (29)
Sibley (72)	Lincoln (41)	Lake of the Woods (39)	McLeod (43)
Steele (74)	Lyon (42)	Mille Lacs (48)	Meeker (47)
Todd (77)	Murray (51)	Mower (50)	Pipestone (59)
Wabasha (79)	Nobles (53)	Olmsted (55)	Pope (61)
Wadena (80)	Rock (67)	Wright (55)	Renville (65)
Waseca (81)	Swift (76)	Red Lake Tribe	Stevens (75)
	Yellow Medicine (87)	Mille Lacs Band (0B1)	Traverse (78)
			White Earth (0B2)

Chris Drury
(651) 431-2773
Back-up: Joan

Carla Turnbom
(651) 431-2525
Back-up: Kay

Karen Bauman
(651) 431-4971
Back-up: Carolyn

Kittson (35)	Becker (03)	Aitkin (01)
Le Sueur (40)	Carlton (09)	Benton (05)
Marshall (45)	Cass (11)	Chisago (13)
Nicollet (52)	Clay (14)	Cottonwood (17)
Pennington (57)	Crow Wing (18)	Faribault (22)
Pine (58)	Mahnomen (44)	Fillmore (23)
Rice (66)	Norman (54)	Hennepin (27)
Roseau (68)	Otter Tail (56)	Isanti (30)
Sherburne (71)	Polk (60)	Jackson (32)
St. Louis (69)	Red Lake (63)	Martin (46)
Scott (70)	Stearns (73)	Ramsey (62)
Washington (82)	Wilkin (84)	Redwood (64)
Winona (85)		Watsonwan (83)

MSHO fax and enrollment forms number: (651) 431-7548

MSC+ and SNBC (MA37) issues contact PMAP/MCRE Enrollment Coordinator

301.03 DHS Managed Care Contract Managers Listing

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UCARE

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301.04 Management Reports

These reports are available for viewing online using Infopac. Most MCOs can also print the reports. Infopac holds a history of past report versions and allows the printing of the entire report, selected pages, or a custom design of pages. The report is a "snapshot" of data and does not allow the user to change the data or the date parameters.

If you are interested in viewing or having the reports print directly at your health plan, contact your Infopac administrator.

The following reports are available to health plan, county, and tribal staff:

- 941A-R2083H Service Agreement/Procedure Code Rate Change
- PWMW9200-R2453 Screening Documents Approved
- PWMW9200-R2455 Suspended LTC Screening Document
- Client Eligibility Change Report

The following report is available to county and tribal staff:

- 185L-R0507 MSHO/MnDHO/SNBC New Enrollee Report

If you have questions regarding the managed care reports, please contact the managed care coordinator listed in the previous chart.

Report Number	Report Name	Description
941A-R2083H	Service Agreement/Procedure Code Rate Change Report	<p>Produced for automated service rate changes in MMIS. Report R2083H identifies changes to the Essential Community Supports (ECS) service agreements and is available to any MCO with members open to this program that meet the report criteria.</p> <p>Staff will use this report to identify changed service agreements due to a "COLA" rate change mandated by the legislature authorizing a rate change for ECS services.</p> <p>If the MCO uses a county agency or other delegate to enter service agreements into the MMIS, that staff needs to review and change</p>

Report Number	Report Name	Description
		<p>the service agreements in MMIS. If the MCO uses form DHS-3070 Service Agreement, make changes on that form and submit securely to DHS through a dedicated email address. See the process outlined on the CBSM-ECS page.</p>
9200-R2453	Screening Documents Approved	<p>Screening documents approved within the reporting period shown for the health care coordinator listed on the screening document. It is not a cumulative report.</p> <p>This monthly report sectioned by the LTCC county field from the LTC screening document then by the care coordinator name when the CM/HP/CA field is populated.</p> <p>This report used to track when screening documents were data entered and approved, and if a service, agreement that includes the screening document's effective date entered during the reporting period.</p>
9200-R2455	Suspended LTC Screening Document	<p>This is a weekly report for the county, tribal agency, health plan, or county based purchasing entity associated with the person in the CM/HP/CA field. If the field is blank on the screening document, the report goes to the county identified in the LTCC County field.</p> <p>It identifies the screening documents that are in suspense for more than two weeks and the number of days since they were data entered. Delete or enter a new screening document that corrects the problem that is keeping the document in suspense. This is a cumulative report.</p> <p>See Session 12 of the MMIS Training Series for instructions on how to find these documents in MMIS.</p>
9200—R2457	LTC Cumulative Service Encumbrance and Payments (Using Date of Service)	<p>This is a monthly report sorted by all health plans with members using ECS services. It lists the cumulative encumbrance and payments of each procedure code as of the</p>

Report Number	Report Name	Description
		<p>service date. There is a section for the current year and a section for the past year. Use it to determine the total encumbered and/or paid amounts for each service during the reporting period, and to compare your average with the state average amounts.</p>
9200-R2460	Cumulative Encumbrance and Payments (Using Date of Service)	<p>This is a monthly report for members with an ECS service agreement showing data by date of service.</p>
	Client Eligibility Changes	<p>It is imperative that timely notification for care coordinators of eligibility changes for persons receiving case management services. Changes in eligibility have an impact on home and community based services, care planning, and service delivery. This report is another tool to provide that information. This report will not replace the Case Manager/Financial Worker Communication form DHS-5181.</p> <ul style="list-style-type: none"> • The report is not cumulative • It is sorted by the care coordinator provider number • Labeled "Report" and placed in the CML folder for the individual MN-ITS mailbox for provider type 27 (health care coordinator). • Includes a page to explain data and suggest possible actions. • Provided on a weekly basis each Friday for persons with a change in one or more of the following: <ul style="list-style-type: none"> ○ Medical Assistance major program begin date, end date, or county of financial responsibility (CFR) ○ Medicare Part A and or Part B begin or end date ○ PPHP Enrollment begin date, end date, health plan, product ID, or disenrollment reason ○ Living Arrangement type, begin or end date

Report Number	Report Name	Description
		<ul style="list-style-type: none"> ○ LTC Ineligibility type, begin or end date ○ Waiver type, begin or end date ○ Date of death
PMMW185M-R0503	PPHP Current Enrollment Report for Provider	The health plan provider number sorts this report, generated after capitation and reports data for the next month. Used it to identify people enrolled with managed care.
PMMW185L-R05070	MSHO/MnDHO/SNBC New Enrollee Report	This report, generated after capitation, identifies people enrolled in managed care (MSHO, MSC+, and SNBC) the following month. It is sorted by the service location and then by health plan. Use it to identify new enrollees who are also on a waiver or Essential Community Supports program.